**ARIZONA DEPARTMENT OF CORRECTIONS**

**MEDICAL TRANSPORTS**

**To be completed for emergency off-site health care transports**

**CONTRACTOR NAME: _____**

**Arizona State Prison Complex Name: _____ For Month and Year: _____ Date Submitted: _____**

| Date of Transport | Inmate Last name | Inmate ADC Number | Transporting Diagnosis | Ordering Provider | Mode of Transport | Air Ambulance Vendor Name | Ground Ambulance Vendor Name | Ultimate Destination | Admitted to Hospital? (Y or N) | Military Time of Incident |
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