Surge Center Trailer Inventory Form (*Completed by Hospitals*)



| Hospital Name | |
|------------------------|------|
| Date Trailer Picked Up | Time |

| h | | | Check One | |
|----|---|-----------------------------|----------------------|----------------------|
| # | Medical Examiner (ME) or Storage (ST) Case # | Patient Name (Please Print) | COVID-19 Positive | COVID-19 Negative |
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