



# SEPARATION VOUCHER

Name	Shield No.	Reference No.	Resignation Date
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The items listed below shall be returned to the **Medical Supply Unit** by the member:

ITEM	CODE	RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
		YES	NO		YES	NO	
OBS Kit	M0085	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Pocket Mask (Adult)	M0095	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Pocket Mask (Pediatric)	M0096	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Stethoscope (Adult)	M0125	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Stethoscope (Pediatric)	M0126	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Technician Bag	M0018	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Oxygen Wrench	M0161	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Broselow Tape (Paramedics only)	M0245	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Glucose	M0075	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Infant Swaddler	M0134	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Goggles	M0237	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

According to MSU records, the following items have been issued but not returned:

A check in this box indicates that no MSU records are available to confirm what was originally issued.

_____ Signature of Member	_____ Signature of MSU Representative	_____ Date
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The items listed below shall be returned to the **Medical Equipment Unit** by the member:

ITEM	CODE	RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
		YES	NO		YES	NO	
BP Cuff (Adult)		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
BP Cuff (Pediatric)		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

_____ Signature of Member	_____ Signature of MEU Representative	_____ Date
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The items listed below shall be returned to the **EMS Division ALS Coordinator** by the member:

ITEM	RECEIVED		RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
	YES	NO	YES	NO		YES	NO	
Controlled Substance Key # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

_____ Signature of Member	_____ Signature of Div. ALS Coordinator.	_____ Date
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The items listed below shall be returned to the **Uniform Quartermaster** by the member:

ITEM	RECEIVED		RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
	YES	NO	YES	NO		YES	NO	
MSA APR Facepiece (Complete)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
MSA Large Optifilter Canister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Mask Carry Pouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
All issued uniform items and personal protective equipment have been returned to the <b>Uniform Quartermaster</b> except the following: Receipt from the Uniform Quartermaster must be attached to this form.								
_____ Signature of Member			_____ Signature of MSU Quartermaster Rep.			_____ Date		

The items listed below shall be returned to the **Haz-Tac Logistics Unit - Randalls Island** by the member:

ITEM	RECEIVED		RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
	YES	NO	YES	NO		YES	NO	
Rescue Helmet with Goggles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Rescue Harness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Rescue Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Headlamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
SCBA Facepiece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
APR Adapter for SCBA Facepiece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
_____ Signature of Member								
_____ Signature of Member			_____ Signature of Haz-Tac Rep..			_____ Date		

The items listed below shall be returned to the **EMS Operations** by the member:

ITEM	RECEIVED		RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
	YES	NO	YES	NO		YES	NO	
Operating Guide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
_____ Signature of Member								
_____ Signature of Member			_____ Signature of EMS Operations Rep.			_____ Date		

The items listed below shall be returned to the **Bureau of Communications (Teleco Unit)** by the member:

ITEM	CODE	RETURNED		REPLACEMENT COST	PAID FOR		TOTAL	
		YES	NO		YES	NO		
Cell phone and accessories		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
Pager and accessories		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
Other (Specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
_____ Signature of Member								
_____ Signature of Member			_____ Signature of BOC Representative			_____ Date		

The items listed below shall be returned to the **Bureau of Communications (EMD)** by the member:

ITEM	CODE	RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
		YES	NO		YES	NO	
Headset		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
"Y" connector		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<hr/> <div style="display: flex; justify-content: space-between;"> <span>Signature of Member</span> <span>Signature of EMD Representative</span> <span>Date</span> </div>							

The items listed below shall be returned to the **Radio Repair Unit** by the member:

ITEM	CODE	RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
		YES	NO		YES	NO	
400 Mhz. Portable Radio		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
400 Mhz. Radio Battery Charger		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
800 Mhz. Portable Radio		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
800 Mhz. Radio Battery Charger		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Fireground Portable Radio		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Fireground Radio Battery Charger		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Interoperability (IO) Portable Radio		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
IO Radio Battery Charger		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Scanner		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<hr/> <div style="display: flex; justify-content: space-between;"> <span>Signature of Member</span> <span>Signature of EMS Radio Repair Rep.</span> <span>Date</span> </div>							

After the above items have been appropriately returned all members must receive a **Bureau of Investigations and Trials** Endorsement:

All members must obtain a signature from the <b>Bureau of Investigations and Trials</b> :	
<hr/>	<hr/>
Signature of B.I.T.S. Representative	Date

After the above sections have been completed all members must receive a **EMS Operations** Endorsement:

All members must obtain a signature from the <b>Chief of EMS Operations or designee</b> :	
<hr/>	<hr/>
Signature of EMS Operations Representative	Date

**Note:** All Members must verify with the EMS Operations that any sections not signed are non-applicable

The items listed below shall be returned to the **Bureau of Personnel** by the member:

ITEM	RECEIVED		RETURNED		REPLACEMENT COST	PAID FOR		TOTAL
	YES	NO	YES	NO		YES	NO	
Shield: Type      Quantity:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Identification Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<hr/> <div style="display: flex; justify-content: space-between;"> <span>Signature of Member</span> <span>Signature of Bureau of Personnel Rep.</span> <span>Date</span> </div>								