SOUTH CENTRAL PA CISM TEAM DEBRIEFING/DEFUSING REPORT
CONFIDENTIAL

No._____

Date of Incident: _____

Requesting Agency: _____

Nature of Incident: _____

_____

_____

Date of Intervention: _____

Type of Intervention: _____

Number of Persons Attending: _____

Team Members: _____ _____

_____ _____

General Impressions of Intervention
No Names!!

_____

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_____

Recommendation for Follow-up:_____

_____

_____ _____
Signature Date

Please return report within 48 hours:
Fax: 717-840-7406
Mail: South Central PA CISM Team, 118 Pleasant Acres Rd., York, PA 17402