



TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
TELEPHONE: (615) 741-2584

ANNUAL SERVICE AUDIT
YEAR _____

Date: _____

Ambulance Service: _____ License#: _____

Ambulance Service Address: _____
Street

_____ City State Zip

Telephone No.: () Fax No.: ()

E-Mail Address: _____

Name of Ambulance Service Director of Record: _____

Working Title: _____

Region: _____ Regional Consultant: _____

Name of Service Personnel Present: _____

TO BE VERIFIED IN AUDIT:

- 1. MEDICAL DIRECTOR INFORMATION:** (Letter required for new Medical Directors)
Rule: 1200-12-01-.14 (3) (a)

Name: _____

Address: _____

Email: _____ Phone: _____

Comments: _____

- 2. PERSONNEL COMPLIANCE**
Rule: 1200-12-01-.15 (1) (a)

Comments: _____

3. **ANNUAL REPORT**
Rule: 1200-12-01-.11 (3)

Comments: _____

4. **INSURANCE INFORMATION** (Official verification of current coverage)
Rule: 1200-12-01-.07 (4) (a) (b) (c)

Comments: _____

5. **FCC RADIO LICENSE** (Official copy of valid license)
Rule: 1200-12-01-.08 (5)

155.205
 Meets requirement with cooperative use agreement.

155.295
 Meets requirement with cooperative use agreement.

155.340
 Meets requirement with cooperative use agreement.

Comments: _____

6. **MECHANIC CERTIFICATION** (Official copy of current certificate.)
Rule: 1200-12-01-.02 (1) (n) (2)

Comments: _____

7. **VEHICLE SAFETY INSPECTIONS**
Rule: 1200-12-01-.02 (1) (n) (1)

Include a completed safety mechanical inspection on each ambulance using form PH-2405. All permitted ambulances must document at least one mechanical inspection, per fiscal year, and/or every 30,000 miles after registering 200,000 miles. The original mechanical inspection form(s) shall be obtained from the service. **Number of ambulances** _____

Comments: _____

8. **PERSONNEL STAFFING**
Rule: 1200-12-01-.15 (2) (a)

Adequate sampling was conducted from the dispatch log or time schedules to determine service classification. Method and Findings (Document process in comments)

Comments: _____

9. **EQUIPMENT INVENTORY**
Rule: 1200-12-01-.15 (4)

Verify completed inventory files, every 72 hours at a minimum, on all permitted vehicles for a 90 day period.

Comments: _____

10. EMERGENCY MEDICAL RESPONDER PROGRAM
Rule: 1200-12-01-.16

No EMR Program

Verify files at the service contain documentation for:

- Agreement (MOA) ...**(2) (e)**
- Insurance Certification (\$300,000) ...**(2) (f)**
- In-Service ...**(2) (b) (3)**
- Personnel Listing of each Service ...**(2) (e) (1)**

Dual Lumen Airway ...**(2) (b) (1) (iv)**

- Approved for use by EMR (leave blank if no)
- Periodic review and concurrent quality assurance

Comments: _____

11. CONTINUOUS QUALITY IMPROVEMENT
Rule: 1200-12-01-.14 (3) (a)

- Medical Director involved.
- CQI process in Policy and Procedure manual

Comments: _____

12. IN-SERVICE TRAINING
Rule: 1200-12-01-.14 (4)

- There is verification of 12 hours Continuing Education/In-service Training for 75% of patient care employees for the past calendar year.

BOARD APPROVED CLINICAL PRACTICES

- Where R.S.I. is an approved skill, competency is documented every 6 months
Rule 1200-12-01-.20 (2)
- Minimum 1.5 hours pediatric training (reference spreadsheet) – 100% required
- Sudden Unexplained Death of a Child (**TCA 68-1-1102 [b]**)
- Vanessa K. Free Emergency Services Training Act (**TCA 55-8-194**)
- Domestic Violence

Comments: _____

13. CLASSIFICATION
Rule: 1200-12-01-.14 (2) (a) and (b)

Review of documentation provided indicates category of:

- Advanced Life Support (A) Extended Life Support (B) Basic Life Support (C)
- Minimum Standard (D) Special (S) Conditional

DEFICIENCIES

(Please include a narrative on all deficiencies cited)

Comments: _____

Audit findings were presented to the Ambulance Service Director on _____
Date

Plan of correction due by: _____
Date

Plan of corrections received on: _____
Date

Additional Comments:

Acceptable

Deficient

Agency Representative or Director Signature

Regional Consultant Signature

TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

ANNUAL OPERATIONS REPORT OF AMBULANCE SERVICE
LICENSE RENEWAL

FOR THE TIME PERIOD REPORTED FROM: _____ TO: _____

SERVICE NAME: _____ COUNTY: _____

SERVICE UTILIZATION

1. _____ Annual Number of **Responses** (Calls or Requests for Service)
2. _____ Annual Number of **Transports**

FIELD PERSONNEL

Please identify the number of patient care personnel *employed* in the following categories by the major responsibilities for that person. **Count each person only once.**

1. _____ Drivers (no EMS or Nursing license)
2. _____ EMR/First Responders
3. _____ Emergency Medical Technicians
4. _____ EMT-IVs
5. _____ AEMTs
6. _____ Paramedics
7. _____ Critical Care Paramedics
8. _____ Registered Nurses

_____ **Total EMS Personnel**

Information

Provided by: _____
Name Title

Date completed: _____