



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

**90-DAY  
AMBULANCE SERVICE REVIEW**

Date: \_\_\_\_\_

Ambulance Service: \_\_\_\_\_ License#: \_\_\_\_\_

Ambulance Service Address: \_\_\_\_\_

Street

City

State

Zip

Telephone No.: (\_\_\_\_) \_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Ambulance Service Director of Record: \_\_\_\_\_

Working Title: \_\_\_\_\_

Region: \_\_\_\_\_ Regional Consultant: \_\_\_\_\_

Name of Service Personnel Present: \_\_\_\_\_

**TO BE VERIFIED IN AUDIT:**

- Medical Director Information: (Letter required for new Medical Directors)

**Rule: 1200-12-01-.14 (3) (a)**

Confirm mailing address

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

- Personnel Compliance

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

- Reporting Method

**Rule: 1200-12-01-.15 (2) (c)**

Verify agency method on reporting patient information upon arrival to hospital.

- 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: \_\_\_\_\_

- Equipment Inventory  
**Rule: 1200-12-01-.15 (4)**

Verify completed inventory files, every 72 hours at a minimum, on all permitted vehicles for a ninety (90) day period.  
 Yes  No if no, explain: \_\_\_\_\_

- Continuous Quality Improvement  
**Rule: 1200-12-01-.14 (3) (a)**

Medical Director involved.  
 CQI process in Policy and Procedure manual

Comments: \_\_\_\_\_

- 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.  
 Yes  No if no, explain: \_\_\_\_\_

- 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

List **all** Deficiencies Sited:  
\_\_\_\_\_

Audit findings were presented to the Ambulance Service Director on \_\_\_\_\_ Date

Plan of correction due by: \_\_\_\_\_ Date

Corrections received and completed: \_\_\_\_\_ Date

**Comments:**  
\_\_\_\_\_

**Acceptable**

**Deficient**

ALL REQUIREMENTS FOR ANNUAL AUDIT HAVE BEEN OUTLINED AND DISCUSSED WITH THE SERVICE DIRECTOR OR DESIGNEE BY THE REGIONAL CONSULTANT DURING THIS NINETY (90) DAY AUDIT REVIEW.

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Agency Representative or Director Signature

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Regional Consultant Signature