



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

INITIAL REVIEW FOR SERVICE LICENSURE

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 from Medical Directors)
Rule: 1200-12-01-.14 (3) (a)
 Confirm mailing address
 Name: _____
 Address: _____
 Email: _____ Telephone: () _____

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

VEHICLE SAFETY INSPECTIONS
Rule: 1200-12-01-.02 (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 Units** _____

CLASSIFICATION

Rule: 1200-12-01-.14 (2) (b)

Upon issuance of a new service license, services are placed in a **conditional** license category until a new review is conducted which can be up to one (1) year from the date of issuance.

DEFICIENCIES

List **all** Deficiencies Sited:

Review 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 LICENSURE HAVE BEEN OUTLINED AND DISCUSSED WITH THE SERVICE DIRECTOR OR DESIGNEE BY THE REGIONAL CONSULTANT DURING THIS INITIAL REVIEW.

Agency Representative or Director Signature

Regional Consultant Signature