



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  
INVALID SERVICE REVIEW**

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

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

Service Address: \_\_\_\_\_  
Street

\_\_\_\_\_

City

State

Zip

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

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

Web Site: \_\_\_\_\_

Service Director: \_\_\_\_\_ Title: \_\_\_\_\_

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

Agency Personnel Present: \_\_\_\_\_

**TO BE VERIFIED IN REVIEW:**

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

Dispatch and Run Records  
**Rule 1200-12-01-.15 (2) (a)**

Classification  
**Rules 1200-12-01-.09 (2)**  
Classification of Service is Invalid

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

**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.

\_\_\_\_\_  
Agency Representative or Director Signature

\_\_\_\_\_  
Regional Consultant's Signature