



INVALID SERVICE AUDIT
YEAR \_\_\_\_\_

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

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

City State Zip

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

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

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

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

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

TO BE VERIFIED IN AUDIT:

- Personnel Compliance Rule 1200-12-01-.15 (1) (a)
Transport records completed Rule 1200-12-01-.09 (6)

TO BE SUBMITTED WITH AUDIT:

- Annual Survey Number of Runs Rule: 1200-12-01-.11 (4)
Annual Mechanical Inspection Number of Units Rule: 1200-12-01-.09 (5)
Vehicle Safety Inspections Rule 1200-12-01-.02, (n) (1)
Insurance Certification Rule 1200-12-01-.07 (To include Auto, General and Malpractice)

**CLASSIFICATION**

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

**DEFICIENCIES**

List **all** deficiencies sited.

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

\_\_\_\_\_

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

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

Plan of corrections received on: \_\_\_\_\_  
Date

**Acceptable**

**Deficient**

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

\_\_\_\_\_  
Regional Consultant Signature