



INITIAL REVIEW FOR SERVICE LICENSURE

Date: _____

Ambulance Service: _____ File#: _____

Region: _____ Regional Consultant: _____

Name of Service Personnel Present: _____

TO BE VERIFIED IN AUDIT:

AMBULANCE SERVICE ADDRESS, TELEPHONE, FAX AND EMAIL

SERVICE DIRECTOR NAME AND CONTACT INFORMATION

MEDICAL DIRECTOR INFORMATION:

Rule: 1200-12-01-.14 (4) (a)

MECHANIC CERTIFICATION (verify current certification)

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** _____

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

Rule: 1200-12-01-.14 (3) (c) 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

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