Appointment Date & Time:

CITY OF McALLEN

Permit #

AMBULANCE INSPECTION REPORT

Date:	Provider Name:	EMS License No.:	Doc #_____ □ with Copy of Insurance Certificate	Company License No.:
Inspection Conducted at Location:			Purpose: □ Initial □ Unannounced □ Re-inspection	
VEHICLE DESCRIPTION: Unit No.:_____ Make:_____ Year:_____ VIN #:_____ License Plate #:_____ ***Verify that LP#s Match: □ Front □ Back* Designation: □ BLS □ ALS □ MICU □ ALS W/MICU Capabilities			Type (Check One): □ I -Truck chassis/Box □ II - Van with Integral cab □ III – Van/Box	
EMS Personnel assigned to identified unit: Name: _____ EMS State License #:_____ Name: _____ EMS State License #:_____ Name: _____ EMS State License #:_____			MEDICAL EQUIPMENT: □ Provide a **COPY** of your Minimum supply list signed by your Medical Director (For our records) □ Provide a **COPY** of DSHS Provider Application (Complete with Protocol) *****NO HARD COPY***** ***Must be in electronic form***	

On this date an inspection was conducted on the provider identified above under the provisions of the City of McAllen Code of Ordinance Chapter Sec. 42-76. The result of this inspection is checked below:

□ Unit inspected was found to be in substantial compliance with City Ordinance and Regulations

□ License Plate Sticker Expiration Date:_____	□ Vehicle Inspection Sticker Expiration Date:_____	□ Company Name Displayed
□ License from State Displayed & Current	□ No Smoking Signs Displayed Front & Rear	□ Emergency Response Guide Book
□ Fire Extinguisher Current Date:_____	□ Protocol Book with Doctor Signature	□ House Oxygen Amount (Check qty on Protocol) _____Psi
□ Portable Oxygen Amount _____psi	□ Emergency Warning Devices Operational	□ Two Way Communication (Type:_____) □ With Hospital (Type:_____) □ With NPSPAC Channels (Type:_____)

All Battery Powered Items Operational

□ Heart Monitor Serial #_____(Last 4 digits) □ Extra Battery	□ AED Serial #_____(Last 4 digits) □ Extra Battery	□ Flashlight/Penlight □ Extra Battery (for Flashlight)	□ Portable Suction □ Extra Container
□ Laryngoscope □ Extra Battery	□ House Suction	□ Glucometer □ Extra Battery □ Strips □ Lancets	□ Pulse Oximeter □ Extra Battery

□ Unit inspected was found to be non-compliant for the reasons listed below:

I certify that the EMS vehicle identified on this form is in response *READY* status: _____ _____ _____ Provider Representative Time Date	I have been informed of the results of this inspection and I have received a copy of this report: _____ _____ _____ Provider Representative Title Date

INSPECTION CONDUCTED BY:_____ ON_____
Name Date

***I understand that if a scheduled appointment is missed or canceled it will be considered a "Failed" inspection and a re-inspection fee will need to be paid unless we have received at least a 24 hour prior request to re-schedule.

Appointment Date & Time: _____ Signature: _____ Date: _____