



Permit #

**AMBULANCE INSPECTION REPORT**

Date & Time:	Provider Name:	DSHS State License No.:	Company License No.:
Inspection Conducted at Location:	Appointment Confirmed 24 hrs prior: <input type="checkbox"/> Yes <input type="checkbox"/> No	Purpose: <input type="checkbox"/> Initial <input type="checkbox"/> Re-inspection <input type="checkbox"/> Update Inspection	
VEHICLE DESCRIPTION: Unit No.: _____ Make: _____ Year: _____ VIN #: _____ <input type="checkbox"/> License Plate #: _____ **Verify that LP#s Match: <input type="checkbox"/> Front <input type="checkbox"/> Back		Type (Check One): <input type="checkbox"/> I - Truck chassis/Box <input type="checkbox"/> II - Van with Integral cab <input type="checkbox"/> III - Van/Box	
I certify that the EMS vehicle identified on this form is in response <i>READY</i> status and understand that once the inspection has begun no personnel, equipment, supplies and/or documents will be allowed to be brought into the vehicle:			
Provider Representative _____ Time _____ Date _____			
EMS Personnel assigned to identified unit: (All personnel arriving in vehicle at time of inspection must be properly identified and must have Driver's License and EMS State License on hand)			
Name: _____		EMS State License #: _____	Driver's License #: _____
Name: _____		EMS State License #: _____	Driver's License #: _____
Name: _____		EMS State License #: _____	Driver's License #: _____

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**

- |   |   |
|---|---|
| <input type="checkbox"/> License Plate Sticker Exp Date: _____  | <input type="checkbox"/> Emergency Response Guide Book (2012 version)           |
| <input type="checkbox"/> Vehicle Inspection Sticker Exp Date: _____   | <input type="checkbox"/> Fire Extinguisher Current Date: _____                  |
| <input type="checkbox"/> Emergency Warning Devices Operational  | <input type="checkbox"/> Protocol Book with Doctor Signature                    |
| <input type="checkbox"/> Insurance Card with corresponding VIN# _____   | <input type="checkbox"/> Minimums Supply List in Protocol with Doctor Signature |
| <input type="checkbox"/> Company Name Displayed   | <input type="checkbox"/> House Oxygen Amount: _____                             |
| <input type="checkbox"/> License from State Displayed & Current   | <input type="checkbox"/> Portable Oxygen Amount: _____                          |
| <input type="checkbox"/> DSHS License Certificate # _____   | <input type="checkbox"/> Two Way Communication (Type: _____)                    |
| Expiration Date: _____  | With Hospital (Type: _____)   |
| Designation: <input type="checkbox"/> BLS <input type="checkbox"/> ALS <input type="checkbox"/> MICU <input type="checkbox"/> ALS W/MICU Capabilities | With NPSPAC Channels (Type: _____)  |
| <input type="checkbox"/> No Smoking Signs Displayed Front & Rear  |   |

**All Battery Powered Items Must Be Operational**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Monitor (test strip & serial # _____) | <input type="checkbox"/> Extra Battery for Laryngoscope           |
| <input type="checkbox"/> Extra Battery for Heart Monitor             | <input type="checkbox"/> House Suction with bag(s) if applicable  |
| <input type="checkbox"/> AED (serial # _____)                        | <input type="checkbox"/> Glucometer                               |
| <input type="checkbox"/> Extra Battery for AED                       | <input type="checkbox"/> Extra Battery for Glucometer             |
| <input type="checkbox"/> Penlight                                    | <input type="checkbox"/> Strips must have expiration date visible |
| <input type="checkbox"/> Flashlight                                  | <input type="checkbox"/> Lancets                                  |
| <input type="checkbox"/> Extra Battery (for Flashlight)              | <input type="checkbox"/> Pulse Oximeter (reading must be taken)   |
| <input type="checkbox"/> Portable Suction                            | <input type="checkbox"/> Extra Battery for Pulse Oximeter         |
| <input type="checkbox"/> Extra Container and/or bag(s)               |   |
| <input type="checkbox"/> Laryngoscope                                |   |

**☐ Unit inspected was found to be non-compliant for the reasons listed below: (this list may not be inclusive)**

I have been informed of the results of this inspection and I have received a copy of this report:		<b>INSPECTION CONDUCTED BY:</b>	
Provider Representative _____	Title _____	Name _____	Date & Time _____