DEPARTMENT OF HUMAN SERVICES
OREGON HEALTH DIVISION
EMERGENCY MEDICAL SERVICES AND SYSTEMS
PO BOX 14450
PORTLAND OR 97293-0450
Telephone No. (503) 731-4011 Extension 633

MARINE AMBULANCE SERVICE PERSONNEL RECORDS INSPECTION FORM

Ambulance Service Name: _____

Names of Persons Conducting Inspection:

Health Division Representative: _____

Representative from Service Assisting with Inspection: _____

Type of Inspection: G Initial G Announced G Unannounced G Reinspection

Date of Inspection: ____/____/____ If Reinspection, Date of Previous Inspection: ____/____/____

Name of EMT, RN, PA or Marine craft Operator: _____

EMT Level: B, I, P Certification Number: _____, RN or PA License Number: _____

Item	Present	Absent	N/A	
Full name;	G	G		
Home address;	G	G		
Work status (PFT, PPT, V);	G	G		
Copy of EMT certification;	G	G	G	Exp. Date: ___/___/___
Copy of RN license;	G	G	G	Exp. Date: ___/___/___
Copy of PA license;	G	G	G	Exp. Date: ___/___/___
Copy of current operator license;	G	G	G	Exp. Date: ___/___/___
Copy of current CPR certificate:				
EMT-B or EMT-I only;	G	G	G	Exp. Date: ___/___/___
Non-EMT operator;	G	G	G	Exp. Date: ___/___/___
Copies of the following for RNs and PAs only:				
Current "Level C" CPR;	G	G	G	Exp. Date: ___/___/___
Current ACLS certification;	G	G	G	Exp. Date: ___/___/___
Pediatric ALS certification;	G	G	G	Exp. Date: ___/___/___
TEAM, TNCC, PHTLS or BTLS certificate;	G	G	G	Exp. Date: ___/___/___

Marine Ambulance Service Personnel Records Inspection Form (Continued)

Item	Present	Absent	N/A	
Documentation that employee has completed an orientation of all policies, training objectives, patient care protocols, regulations, and statutes;	G	G		Comp Date: __/__/__
Signed Statements:				
Not addicted to alcohol or controlled substances;	G	G	G	
Is free from any physical or mental defect that might impair ability to operate an ambulance;	G	G	G	
Verification that the operator can properly lift and move patients;	G	G	G	
Documentation of test for Tuberculosis or signed waiver;	G	G		Test Date: __/__/__
Documentation for immunizations for Hepatitis-B or signed waiver;	G	G		Imm. Date: __/__/__
Documentation received blood borne pathogen and infectious disease training per OSHA requirements, within the last twelve months;	G	G		Comp Date: __/__/__
Documentation received hazardous materials awareness training per OSHA requirements, within the last twelve months;	G	G		Comp Date: __/__/__
Prehospital emergency medical care continuing education records for in-house training.	G	G		