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

AMBULANCE SERVICE SATELLITE FACILITIES INSPECTION FORM

Ambulance Service Name: ______________________________

Address of Satellite Office: ______________________________

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: ____/____/____

Time Inspection Began: ____:____ am pm Time Inspection Concluded: ____:____ am pm

Satellite Location Crews Quarters:	**Yes**	**No**	**Date and Time Corrected**	**Comments**
Building in good repair;	G	G	____/____/____ ________	
Free from fire and safety hazards;	G	G	____/____/____ ________	
Facilities have clean floors, walls and ceiling and are free from vermin.	G	G	____/____/____ ________	
Rest area;	G	G	____/____/____ ________	
Toilet;	G	G	____/____/____ ________	
Hand washing facilities with hot and cold running water and antiseptic soap;	G	G	____/____/____ ________	
Shower facilities with hot and cold running water and antiseptic soap;	G	G	____/____/____ ________	
Clean towels for hand and body drying;	G	G	____/____/____ ________	
Washer and Dryer meeting OSHA requirement for the cleaning of uniforms contaminated with medical biohazardous waste; and	G	G	____/____/____ ________	
Designated area and container(s) for storage of medical biohazardous waste.	G	G	____/____/____ ________	
Satellite Location Ambulance Equipment and Medication Storage Room(s):				
Building in good repair;	G	G	____/____/____ ________	
Free from fire and safety hazards;	G	G	____/____/____ ________	
Facilities have clean floors, walls, and ceiling and are free from vermin;	G	G	____/____/____ ________	
All equipment and medications are reasonably safe from water and fire damage and are stored in a clean and orderly manner in a locked cabinet or room;	G	G	____/____/____ ________	
Designated area for operational equipment;	G	G	____/____/____ ________	

Storage Room(s) (Continued):	**Yes**	**No**	**Date and Time Corrected**	**Comments**
Designated area for broken or non-operational equipment;	G	G	____/____/____ ________	
Designated area for unused medications;	G	G	____/____/____ ________	
Designated area for out-dated medications;	G	G	____/____/____ ________	
Locked cabinet or safe for controlled substances;	G	G	____/____/____ ________	
Physician's DEA license, if controlled substances are maintained on site;	G	G	____/____/____ ________	
Controlled substances inventory book;	G	G	____/____/____ ________	
Medical Oxygen, tanks are properly secured;	G	G	____/____/____ ________	
Designated area for clean laundry; and	G	G	____/____/____ ________	
Designated area for dirty laundry.	G	G	____/____/____ ________	
Satellite Ambulance Garage:				
Garage in good repair;	G	G	____/____/____ ________	
Free from fire and safety hazards;	G	G	____/____/____ ________	
Facilities have clean floors, walls, and ceiling and are free from vermin;	G	G	____/____/____ ________	
Heated to 60 degrees or each ambulance is equipped with suitable engine block, passenger compartment, and drug heaters; and	G	G	____/____/____ ________	
Designated area and container(s) for storage of medical biohazardous waste.	G	G	____/____/____ ________	

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SPACE FOR ADDITIONAL COMMENTS:

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I, the undersigned representative of the ambulance service that has been inspected by the Oregon Health Division, acknowledge receipt of a copy of this inspection form. I understand that if there were discrepancies found during the inspection, the Division may assess a civil money penalty and/or suspend or revoke the ambulance service license or place the ambulance service on probation as prescribed in ORS 682.175 and 682.185.

____
Signature Date

Inspected by: ____
Signature Date