



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



AIR 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 Pilot: _____

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 pilot license;	G	G	G	Exp. Date: ____/____/____
Copy of current CPR certificate:				
EMT-B or EMT-I only;	G	G	G	Exp. Date: ____/____/____
Non-EMT pilot;	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: ____/____/____

Air 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: ___ / ___ / ___
Documentation that employee has completed Division approved air ambulance training course;	G	G	G	Comp Date: ___ / ___ / ___
Documentation that employee has completed medical director approved annual air ambulance refresher training;	G	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 pilot 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		