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 FACILITIES AND RECORDS INSPECTION FORM

Ambulance Service Name: _____

Names of Persons Conducting Inspection:
Health Division Representative:_____

Ambulance Service Representative 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

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Owner's or EMS Manager's Office:	**Yes**	**No**	**Date and Time Corrected**	**Comments**
Location: _____				
Building in good repair;	G	G	____/____/____ _____	
Free from fire and safety hazards; and	G	G	____/____/____ _____	
Facilities have clean floors, walls, and ceiling and are free from vermin.	G	G	____/____/____ _____	
Main Business Office:				
Location: _____				
Building in good repair;	G	G	____/____/____ _____	
Free from fire and safety hazards; and	G	G	____/____/____ _____	
Facilities have clean floors, walls, and ceiling and are free from vermin.	G	G	____/____/____ _____	
Business Licenses and Records:				
Health Division's ambulance service license is conspicuously displayed;	G	G	____/____/____ _____	
Health Division's laboratory license to conduct blood glucose level testing is conspicuously displayed - Expiration date: ___/___/___;	G	G	____/____/____ _____	
Other city, county or State ambulance service License(s) are displayed or on file;	G	G	____/____/____ _____	
All business records are reasonably safe from water and fire damage;	G	G	____/____/____ _____	
All prehospital care report forms used for billing purposes are stored in locked cabinets or a separate locked room with limited access;	G	G	____/____/____ _____	
Maintains a current list of ambulance rates and is made available to the public;	G	G	____/____/____ _____	
Medicare and medicaid provider/vendor numbers: _____ & _____;	G	G	____/____/____ _____	

Main Business Office (Continued):	**Yes**	**No**	**Date and Time Corrected**	**Comments**
Secretary of State Corporation Division documents listing the business name and all ambulance service trade names, if any;	G	G	____/____/____ _____	
Signed power of attorney document(s);	G	G	____/____/____ _____	
Copies of any variance granted by the Division;	G	G	____/____/____ _____	
Signed mutual aid agreements with all adjoining ambulance services;	G	G	____/____/____ _____	
Signed contract(s) with teaching institution(s), if service provides EMT-Paramedic internships;	G	G	____/____/____ _____	
Maintains current copies of all applicable rules and documents referred to in the rules and makes them available to employees/volunteers;	G	G	____/____/____ _____	
Copies of registration for each vehicle, aircraft and watercraft;	G	G	____/____/____ _____	
Copies of Health Division ambulance license, yellow copy for each ambulance;	G	G	____/____/____ _____	
Certificates of Insurance:				
Name of Ins: _____				
Automobile liability;	G	G	____/____/____ _____	
Expiration date:_____/_____/_____				
Name of Ins: _____				
Aircraft liability, **if applicable;**	G	G	____/____/____ _____	
Expiration date:_____/_____/_____				
Name of Ins: _____				
EMT, RN and PA professional liability;	G	G	____/____/____ _____	
Expiration date:_____/_____/_____				
Air carrier operating certificate, **if applicable;**	G	G	____/____/____ _____	
FAA Form(s) 337, **if applicable;** and	G	G	____/____/____ _____	
US Coast Guard certificate, **if applicable.**	G	G	____/____/____ _____	
Policies and Procedures:				
A policy and procedure must be able to answer the questions Who? What? Why? Where? and When?				
Policy to orientate all new employees/volunteers as to the minimum state, county, city standards and company policies;	G	G	____/____/____ _____	
Policy to provide training for all employees/ volunteers on the proper use of any new equipment, procedure or medication prior to being placed on an ambulance;	G	G	____/____/____ _____	
Policy to require the release of copies of all records of training and continuing education conducted by the service and obtained by the EMT within five days of being requested;	G	G	____/____/____ _____	
Policy for employees/volunteers to inform management if employee/volunteer is unable to continue to work because of illness, injury or lack of rest that would jeopardize patient care;	G	G	____/____/____ _____	
Policy for handling biohazardous waste, storage and disposal operating procedures;	G	G	____/____/____ _____	
Policy for destroying outdated medications, to include controlled substances, if authorized by the medical director;	G	G	____/____/____ _____	

Policies and Procedures (Continued):	Yes	No	Date and Time Corrected	Comments
Policy pertaining to patient rights, including maintaining patient care reports in a confidential manner;	G	G	____/____/____ _____	
Policy pertaining to the retention period and the destruction of prehospital care report forms;	G	G	____/____/____ _____	
Policy pertaining to the preventative maintenance of the ambulance(s);	G	G	____/____/____ _____	
Policy for removing an ambulance from service;	G	G	____/____/____ _____	
Policy for notifying the Division within 30 days of having a vehicle, aircraft or watercraft accident.	G	G	____/____/____ _____	
Advertising the Ambulance Service:				
Advertises inside the front cover of the telephone book only;	G	G	____/____/____ _____	
Advertises in the telephone book yellow pages;	G	G	____/____/____ _____	
Advertises or promotes the use of only "9-1-1" for emergency ambulance service;	G	G	____/____/____ _____	
When using the term "For Emergencies - Call 9-1-1" in any print or video advertising, it is in bold-face type at least 1½ times the point size in which the non-emergency or business telephone number is displayed;	G	G	____/____/____ _____	
Advertising materials are for services that are available 24 hours-a-day, 7 days-a-week and 365 days-a-year; and	G	G	____/____/____ _____	
Maintains copies of all print, audio, video, and all other types of advertisements for one year after the use and distribution has ceased.	G	G	____/____/____ _____	
Ambulance Personnel Records				
Personnel records are maintained in one central location: _____	G	G	____/____/____ _____	
The personnel records of EMTs, RNs, PAs, and physicians consist of:				
Full name;	G	G	____/____/____ _____	
Full home address;	G	G	____/____/____ _____	
Indication if they are paid full-time, paid part-time or volunteer;	G	G	____/____/____ _____	
Copies of all certificates and licenses;	G	G	____/____/____ _____	
The personnel records of drivers or pilots consist of:	G	G	____/____/____ _____	
Full name;	G	G	____/____/____ _____	
Full home address;	G	G	____/____/____ _____	
Indication if they are paid full-time, paid part-time or volunteer;	G	G	____/____/____ _____	
Copy of driver or pilot license;	G	G	____/____/____ _____	
Copy of EMT certificate, if certified;	G	G	____/____/____ _____	
Copy of driving record for the past three years or documentation that the service participates in the Department of Motor Vehicles automatic flag program;	G	G	____/____/____ _____	

Personnel Records (Continued):	**Yes**	**No**	**Date and Time Corrected**	**Comments**
If not certified as an EMT, a copy of: Current CPR certificate (ground ambulance driver only);	G	G	____/____/____	_____
If not certified as an EMT, a signed statement by the driver indicating: Not addicted to alcohol or any controlled substance;	G	G	____/____/____	_____
Is free from any physical or mental defect that might impair his/her ability to operate an ambulance;	G	G	____/____/____	_____
Verification that the non-EMT ground ambulance driver can properly assist in the lifting and moving of patients;	G	G	____/____/____	_____
Both patient care personnel and driver personnel records have documentation that: he or she has received a test for Tuberculosis or has a signed waiver;	G	G	____/____/____	_____
he or she has received immunizations for Hepatitis or has a signed waiver;	G	G	____/____/____	_____

Dispatcher Personnel Records:

Ambulance service does not employ dispatchers.	G	**This section is not applicable for this inspection.**		
Personnel records are maintained in one central location; _____	G	G	____/____/____	_____
The personnel records of dispatchers consist of:				
Full name;	G	G	____/____/____	_____
Full home address;	G	G	____/____/____	_____
Indication if they are paid full-time, paid part-time or volunteer;	G	G	____/____/____	_____
Copy of current EMT or FR certificate	G	G	____/____/____	_____
Copy of current CPR Certificate; and	G	G	____/____/____	_____
Copy of DPSST dispatcher training cert.	G	G	____/____/____	_____

Medical Director Personnel Records:

Medical Director's Name:_____				
Copy of contract or agreement with medical director: Date signed: ___/___/___ Date expires: ___/___/___	G	G	____/____/____	_____
Copy of medical director's current physician license issued by the BME;	G	G	____/____/____	_____
DEA license for each location where controlled substances are stored. This does not include controlled substances that are on an ambulance: Date issued: ___/___/___ Date expires: ___/___/___	G	G	____/____/____	_____
Copy of quality assurance program developed and approved by the medical director to include documentation procedures, remedial training, disciplinary action, etc.; and	G	G	____/____/____	_____
Copy of standing orders for each level of certification, signed within one year.				
EMT-Basic - Date signed: ___/___/___	G	G	____/____/____	_____
EMT-Intermediate - Date signed: ___/___/___	G	G	____/____/____	_____
EMT-Paramedic - Date signed: ___/___/___	G	G	____/____/____	_____

Dispatching Center:	**Yes**	**No**	**Date and Time Corrected**	**Comments**
Ambulance service does not provide 24-hour dispatching services. Location: _____	G **This section is not applicable for this inspection.**			
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	____/____/____	_____
Provides 24 hour-a-day telephone answering and dispatching capabilities;	G	G	____/____/____	_____
Dispatching Records and Procedures:				
Federal Communications Commission license is displayed and is current or has proper authorization from the agency holding the license to operate on the designated radio frequencies;	G	G	____/____/____	_____
Procedures for alerting ambulance crew at either the satellite quarters, work or home;	G	G	____/____/____	_____
Procedures for routing emergency calls received on the seven digit business telephone number to the appropriate PSAP;	G	G	____/____/____	_____
Provides that any request for an ambulance received on the seven digit telephone number is answered by a live person or have an answering machine referring the caller to a PSAP; and	G	G	____/____/____	_____
Copies of dispatching records maintained for a minimum of seven years.	G	G	____/____/____	_____
Training Director's Office:				
Location: _____				
Training Director's Name: _____				
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; and	G	G	____/____/____	_____
All prehospital care report forms used for quality assurance purposes are stored in locked cabinets or in a separate locked room.	G	G	____/____/____	_____
Classroom:				
Location: _____				
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; and	G	G	____/____/____	_____
Adequate space, tables, chairs and teaching aids for conducting in-house training.	G	G	____/____/____	_____
EMT Training & Continuing Education Records				
All EMT training records are reasonably safe from water and fire damage and are stored in a locked cabinet for a minimum of four years;	G	G	____/____/____	_____

EMT Training & Continuing Education Records	Yes	No	Date and Time Corrected	Comments
All course rosters contains the following information:				
Name of agency;	G	G	____/____/____	_____
Course subject;	G	G	____/____/____	_____
Course date;	G	G	____/____/____	_____
Length of course;	G	G	____/____/____	_____
Name and signature of instructor;	G	G	____/____/____	_____
Name and signature of EMT attending the course;	G	G	____/____/____	_____
Documentation that ambulance personnel have received bloodborne pathogen and infectious disease training as prescribed by OSHA. This includes initial an annual refresher training;	G	G	____/____/____	_____
Documentation that ambulance personnel have received hazardous materials awareness training meeting the requirements prescribed by OSHA. This includes initial and annual refresher training;	G	G	____/____/____	_____
Documentation of completing a ground ambulance emergency operator's course; and	G	G	____/____/____	_____
Documentation that the dispatchers employed by the service have completed dispatcher training as prescribed by DPSST.	G	G	____/____/____	_____
Air Ambulance Services only:				
Maintains a copy of acceptable air medical crew training curriculum, if operating an air ambulance;	G	G	____/____/____	_____
Documentation that air ambulance personnel have completed the air medical crew training curriculum; and	G	G	____/____/____	_____
Documentation that air ambulance personnel have completed an annual review of the air medical crew training as prescribed by the medical director.	G	G	____/____/____	_____

Main Business Location Ambulance Equipment and Medication Storage Room(s):				
Ambulance service does not store equipment and medications at this location.	G	**This section is not applicable for this inspection.**		
Location: _____				
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	____/____/____	_____
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	____/____/____	_____

Storage Room(s) (Continued) :	**Yes**	**No**	**Date and Time Corrected**	**Comments**
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	____/____/____ _____	

Main Business Location Crews Quarters:

Ambulance service does not have crew quarters at this location.	G	**This section is not applicable for this inspection.**		
Location:_____				
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	____/____/____ _____	

Main Ambulance Garage:

Ambulance service does have an ambulance garage at this location.	G	**This section is not applicable for this inspection.**		
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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Personnel Records Inspection:

See attached personnel records inspection form(s).

Satellite Crew Quarters Inspection:

See attached ambulance service satellite facilities inspection form(s).

Air, Ground and Marine Ambulance Inspection:

See attached air, ground or marine ambulance inspection form(s)

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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