

PENNSYLVANIA DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES OFFICE

AMBULANCE LICENSE INSPECTION CHECKLIST FOR GROUND
AMBULANCE SERVICES

Name of Ambulance Service: _____

Affiliate #: _____

Date of Inspection: _____

The following policy statements and other documentation were available and inspected as part of the ambulance license process:

Policy Statements:

- | | | |
|---|------------------------------|-----------------------------|
| a. Infection Control | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Management of Personnel Safety | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Substance Abuse in the Workplace | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Placement and Operation of Ambulances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Patient Management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Use of Lights and Warning Devices | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Weapons and Explosives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Completion of EMS Patient Care Reports | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Satisfying Documentation Requirements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Satisfying Ambulance Standards | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Satisfying Equipment and Supply Requirements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Satisfying Personnel Requirements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Communicating with PSAPs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Accident, Injury and Fatality Reporting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. Medical Command Notification | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p. Monitoring Statutory and Regulatory Compliance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q. Dissemination and Protection of Patient Information | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r. Participation in Statewide and Regional Quality Improvement Programs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s. Drug Use, Control and Security | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other Documentation:

- | | | |
|---|------------------------------|-----------------------------|
| a. Form for Duty Roster or Staff Availability Schedule, | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Duty Roster or Staff Availability Schedule, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Call Volume Records, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Record of Notification to PSAP of Ambulance Unavailability,
if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e Management Service Contracts, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. EMS Patient Care Reports, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |