

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

Other Documentation:

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