TN Department of Health

90-DAY
AMBULANCE SERVICE REVIEW

Date: _____

Ambulance Service: _____ License#: _____

Ambulance Service Address: _____
Street

_____ _____ _____
City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Email Address: _____

Name of Ambulance Service Director of Record: _____

Working Title: _____

Region: _____ Regional Consultant: _____

Name of Service Personnel Present: _____

TO BE VERIFIED IN AUDIT:

☐ Personnel Compliance
Rule: 1200-12-01-.15 (1) (a)

☐ Reporting Method
Rule: 1200-12-01-.15 (2) (c)

Verify agency method on reporting patient information upon arrival to hospital.

_____

☐ Personnel Staffing
Rule: 1200-12-01-.15 (2) (a)

Adequate sampling was conducted from the dispatch log or time schedules to determine service classification. Method and Findings (Document process in comments)
Comments: _____

☐ Equipment Inventory
Rule: 1200-12-01-.15 (4)

Verify completed inventory files, every 72 hours at a minimum, on all permitted vehicles for a ninety (90) day period.

☐ Yes ☐ No if no, explain: _____

DIVISION OF HEALTH LICENSURE AND REGULATION • **OFFICE OF EMERGENCY MEDICAL SERVICES**
665 MAINSTREAM DRIVE • NASHVILLE, TN 37243
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☐ Continuous Quality Improvement
Rule: 1200-12-01-.14 (4) (a) 1(ii)

☐ Medical Director involved.
☐ CQI process in Policy and Procedure manual

Comments: _____

☐ In-Service Training
Rule: 1200-12-01-.14 (5).

There is verification of plan to complete 15 hours Continuing Education/In-service Training for 95% of patient care employees within calendar year.

☐ Yes ☐ No if no, explain: _____

☐ Classification
Rule: 1200-12-01-.14 (3) (a) (b) (c)

Review of documentation provided indicates designate level:
☐ Advanced Life Support ☐ Basic Life Support ☐ Special ☐ Conditional

Review of documentation provided indicates Class:
☐ Primary Emergency Provider ☐ Licensed Ambulance Transport ☐ Volunteer Not-for-profit

☐ Deficiencies

List **all** Deficiencies Sited:

_____

_____

Audit findings were presented to the Ambulance Service Director on _____
Date

Plan of correction due by: _____
Date

Corrections received and completed: _____
Date

Comments:

_____

☐ **Acceptable**

☐ **Deficient**

ALL REQUIREMENTS FOR ANNUAL AUDIT HAVE BEEN OUTLINED AND DISCUSSED WITH THE SERVICE DIRECTOR OR DESIGNEE BY THE REGIONAL CONSULTANT DURING THIS NINETY (90) DAY AUDIT REVIEW.

_____
Agency Representative or Director Signature

_____
Regional Consultant Signature