



TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
TELEPHONE: (615) 741-2584

AIR MEDICAL SERVICE

INITIAL REVIEW

ANNUAL AUDIT - YEAR _____

Helicopter Fixed Wing

Date: _____

Air Ambulance Service: _____

Air Ambulance Service Address: _____
Street

_____ City State Zip

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

E-Mail Address: _____

Name of Air Ambulance Service Director of Record: _____

Working Title: _____

Region: _____ Regional Consultant: _____

Name of Service Personnel Present: _____

VERIFY CURRENT FAA LICENSE INFORMATION

Certificate Number: _____ Effective Date: _____

Part 135: Yes No Part 91 only: Yes No

MEDICAL DIRECTOR QUALIFICATIONS

Rule 1200-12-01-.05 (5) (a)

Medical Directors Name: _____

Medical Directors Email Address: _____

Currently Licensed In State of Tennessee

Board Certified or Eligible: General or Trauma Surgery, Family Practice, Internal Medicine, Pediatrics, Emergency or Aerospace Medicine

ACLS or Eligible for Board Certification in Emergency Medicine

ATLS and PALS or Neonatal Resuscitation Program and Knowledge Regarding Altitude Physiology/Stressors of Flight (Unless Board Certified or Eligible for Board Certification in Emergency Medicine)

PERSONNEL QUALIFICATIONS

Rule 1200-12-01-.05 (5) (c)

- Check Training Records To Complete Attached Log

Comments: _____

OPERATIONS MANUAL FOR FLIGHT CONTROL OFFICE

Rule 1200-12-01-.05 (6)

- Medical Indications and Contraindications for Flight

Comments: _____

- Call Verifications Procedures and Advisories

Comments: _____

- Radio and Telephone Notification

Comments: _____

- Post Accident / Incident Plan

Comments: _____

- Communication Failure

Comments: _____

- Overdue Transports

Comments: _____

- Downed Aircraft Search and Rescue

Comments: _____

- Requesting Party Briefing for Arrival and Termination

Comments: _____

- Any Deviation of ETA Greater Than 5minutes

Comments: _____

DISPATCH RECORDS

- Flight Number

Comments: _____

- Type of Mission

Comments: _____

- Aircraft Number

Comments: _____

- Flight Crew and Passengers

Comments: _____

- Origin

Comments: _____

- Destination

Comments: _____

Referring and Receiving Doctor

Comments: _____

Date and Significant Times

Comments: _____

Requesting Agency and Contact Person

Comments: _____

PATIENT RECORDS

Rule 1200-12-01-.05 (9)

An Appropriate Sample Of Reports Will Be Reviewed To Substantiate Completion Of Patient Records

Patients Name

Comments: _____

Date of Transport

Comments: _____

Documentation of Treatment

Comments: _____

Origin

Comments: _____

Destination of Flight

Comments: _____

Type of Mission

Comments: _____

Medical Personnel

Comments: _____

Ground Service Accessible

Comments: _____

Chief Complaint

Comments: _____

CONTINUOUS QUALITY IMPROVEMENT

Rule 1200-12-01-.05 (10) (11)

Utilization Review

Comments: _____

Quality Improvement

Comments: _____

REVIEW OF FLIGHT INFORMATION

Rule 1200-12-01-.05 (9) (a) 2

Number of Transfers: _____ Time Period: From _____ To _____

Comments: _____

INSTRUCTION MATERIALS FOR EMS PROVIDERS WITHIN RESPONSE AREA (HELICOPTER ONLY)

Rule 1200-12-01-.05 (4)

Printed Material to Include:

Control of Helicopter Access

Comments: _____

Ground to Air Communications on the Scene

Comments: _____

AIR MEDICAL COMMUNICATION SPECIALIST (HELICOPTER ONLY)

Rule 1200-12-01-.05 (5) (f)

Certification Minimum EMT

Comments: _____

At Least Two (2) Years of Emergency Medical or Emergency Communications Experience

Comments: _____

Initial and Recurrent Training

Comments: _____

NAACS Certified (Within 12 Months)

Comments: _____

Scheduling (No more than 16 Hrs in a 24 Hr period)

Comments: _____

TELECOMMUNICATIONS (HELICOPTER ONLY)

Rule 1200-12-01-.05 (7)

EMS 155.205

Comment: _____

EMS 155.340

Comment: _____

Supplemental Telephone No.: (_____) _____

Direct Telephone No.: (_____) _____

Recording Equipment for Telephone and Radio with Instant Recall

Comment: _____

DEFICIENCIES

List **all** Deficiencies Sited:

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

Plan of correction due by: _____ Date

Plan of corrections received on: _____ Date

- Acceptable**
- Deficient**

Agency Representative or Director Signature

Regional Consultant Signature