



Oklahoma State Department of Health
 Protective Health Services
 Emergency Systems/EMS Division
 1000 N.E. 10th Street
 Oklahoma City, OK 73117-1299
 Telephone: (405) 271-4027
 Fax: (405) 271-4240



EMS AGENCY RECORDS REVIEW FORM	Date:	Time:
	Agency Name:	
OSDH Representative:		
Agency Representative:		

AGENCY INFORMATION

Agency Licensure Level: <input type="checkbox"/> Basic <input type="checkbox"/> Advanced <input type="checkbox"/> Paramedic	Medical Director Information: Name: _____ Phone Number: _____ Email: _____
Individual Protocols: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Advanced <input type="checkbox"/> Paramedic	EMS Director Information: Name: _____ Phone Number: _____ Email: _____
Number of Ambulances: ____ "A" Permit ____ "B" Permit	Substations: <input type="checkbox"/> Yes <input type="checkbox"/> No Locations: _____ Posts: <input type="checkbox"/> Yes <input type="checkbox"/> No Locations: _____

ITEM APPROVED	Y	N	ITEM APPROVED	Y	N
License displayed in the business office Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Medication List with quantities to be carried on ambulances Comments:	<input type="checkbox"/> N/A	<input type="checkbox"/>
Run Log (run#, times, location of call, pt. name, ambulance origination, nature of call) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic Log and Security Comments:	<input type="checkbox"/> N/A	<input type="checkbox"/>
Run Reports Accessible (Past 3 Years) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Operational Policy/Protocols Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Data Collection Current Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Mutual Aid Agreements Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Vehicle Inspection Reports Completed Daily or After Every Run (whichever is least) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Proof of a Medical Director Supervised QA/QI Process Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Vehicle Maintenance Log(s) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Copy of State Approved Medical Protocols Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Staffing Schedules (Past 3 Years) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	Proof of Vehicle and General Liability Insurance (\$1 Million) Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Personnel Folder for Each Employee			Proof of Workers' Compensation Insurance Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Current State License	<input type="checkbox"/>	<input type="checkbox"/>	Surety Bond or Contractual Liability Insurance Comments:	<input type="checkbox"/> N/A	<input type="checkbox"/>
Continuing Education / In-Service Training	<input type="checkbox"/>	<input type="checkbox"/>	OSHA Approved Exposure Control Plan Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Proof of EVOC Training (Every 2 Years)	<input type="checkbox"/>	<input type="checkbox"/>	Safety and Sanitation of Facility and Personnel Comments:	<input type="checkbox"/>	<input type="checkbox"/>
Current CPR Card	<input type="checkbox"/>	<input type="checkbox"/>			
Current ACLS Card (Paramedic Only) <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>			
State Approved Individual Protocol Letter <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:					

* See O.A.C. 310:641 Rules for complete list of required records

Random EMS Training Records Checklist

Medical Provider Name	Level of Licensure	License Expiration Date	Last EVO Class	CPR Expiration Date	ACLS Expiration Date	Individual Protocols Date	ICS Training		
							100	200	700
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

CITATION OF LAW: THIS INSPECTION HAS BEEN CONDUCTED PURSUANT TO TITLE 63, SECTION 2501 AND THE EMS RULES PROMULGATED BY THE STATE BOARD OF HEALTH – OKLAHOMA ADMINISTRATIVE CODE 310:641

I have been given/offered a copy of this inspection report and understand the basis of this report. I also understand that OSDH/EMS recommends all of the above (if any) deficiencies be corrected immediately.

I will provide OSDH/EMS written notification of correction by: _____ / _____, 20_____

Signature of Agency Representative Date

I have inspected the above named Ambulance Provider files/records at the time and date shown above and have found each item as shown within this report.

Signature of OSDH Representative Date

Additional Comments: