

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
 Division of Emergency Medical Services and Highway Safety
OFF-ROAD / SEMSV INSPECTION FORM

PROVIDER NAME _____ REGION _____ PROVIDER NUMBER _____ VEHICLE _____

PROVIDER ADDRESS _____ CITY/STATE/ZIP _____

VEHICLE DESCRIPTION _____

GARAGE ADDRESS _____ V.I.N. _____

LOCAL I.D. _____ **ALS ILS BLS** _____ EMS SYSTEM _____ DATE ____/____/____

- INITIAL REINSPECTION 3rd PARTY COMPLAINT OTHER (SEE COMMENTS FORM) WAIVER (ATTACHED)
- ISSUE LICENSE REINSPECTION REQUIRED (NON-LIFE THREATENING EQUIPMENT PROBLEMS) **ADVISORY STATEMENT— DO NOT OPERATE UNTIL REPAIRED AND REINSPECTED.**

LEGAL ACTION IS REQUIRED FOR THE FOLLOWING: A CONDITION HAS BEEN IDENTIFIED THAT COULD RESULT IN HARM TO THE PUBLIC. THIS VEHICLE SHOULD BE REMOVED FROM SERVICE UNTIL ALL CORRECTIONS ARE MADE AND THE VEHICLE IS REINSPECTED AND APPROVED BY I.D.P.H. (SEE INSPECTION COMMENT FORM).

OFF-ROAD SEMSC

- | | |
|--|--|
| <p><input type="checkbox"/> HAS SUFFICIENT SPACE FOR ONE SUPINE PATIENT AND PERSONNEL TO CARE FOR PATIENT</p> <p><input type="checkbox"/> HAS LOCKING MECHANISM TO SECURE LITTER/STRETCHER OR BACKBOARD TO VEHICLE</p> <p><input type="checkbox"/> LIST IS AVAILABLE SHOWING MEDICAL SUPPLIES/EQUIPMENT REQUIRED FOR EACH MISSION AS DETERMINED BY THE EMSMD; BASED ON PATIENT TYPE, MEDICAL CONDITION AND ANTICIPATED TREATMENT</p> | <p><input type="checkbox"/> HAS APPROPRIATE MEDICAL EQUIPMENT/DRUGS AVAILABLE FOR THE MISSIONS</p> <p><input type="checkbox"/> SEMSC CAN COMMUNICATE WITH DISPATCH CENTER FOR NON-MEDICAL PURPOSES ON A SEPARATE NON-MEDICAL RADIO FREQUENCY</p> <p><input type="checkbox"/> CAN COMMUNICATE WITH HOSPITAL</p> |
|--|--|

COMMENTS

As owner/representative, I agree to provide off-road SEMSC service in compliance with the Emergency Medical Services Act rules and regulations, 24 hours a day, every day of the year. Each off-road SEMSC will be staffed by at least two emergency medical technicians (EMTs) on BLS missions. If operated at the intermediate or paramedic level, the vehicle will be staffed by one EMT with the appropriate license for the level of care at which the vehicle is being operated and one other EMT, pre-hospital RN or physician.* I agree to provide emergency service within my service area on a per need basis without regard to a patient's ability to pay.
 *State minimum requirements; EMS systems may require a higher level of staffing.

PRE-HOSPITAL CARE PROVIDER/OWNER OR REPRESENTATIVE SIGNATURE/TITLE _____ ILLINOIS DEPT. OF PUBLIC HEALTH REPRESENTATIVE SIGNATURE/TITLE _____