

ALS / BLS EMERGENCY MEDICAL RESPONDER VEHICLE AND MEDICAL EQUIPMENT INSPECTION FORM

Inspection Date: ____/____/____ Type of Inspection: Annual Random Reinspection Vehicle No. : _____ Mileage: _____

VIN #: _____ License Tag #: _____ Vehicle Type: _____ Other: _____

If reinspection, date of previous inspection: ____/____/____

I, the undersign represent OKCFD, TFD, EFD, WRFD, BxFD, SSFD, VFD, NFD, WAFD, BFD, PFD, OakCFD, MFD, YFD, DCFD – (circle one) acknowledge receipt of a copy of this inspection form. I am aware of deficiencies listed, (if any) and understand that failure to correct deficiencies will subject this agency and its authorized representatives to administrative action.

Copy of form received by: SO QA DC Other: _____ Signature: _____

Date: ____/____/____ Inspected by: _____ Date: ____/____/____ Medical Director: _____ Date: ____/____/____

Inspector's Notes:

Updated 12/4/2015

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APPROVED BY MCB: / EFFECTIVE DATE: