



**MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
GROUND AMBULANCE SERVICE LICENSURE INSPECTION FORM**

Initial Inspection
 Relicensure Inspection
 Audit
 Complaint Investigation

NAME OF AMBULANCE SERVICE _____	LOCATION _____	DATE _____
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(1) GENERAL REQUIREMENTS FOR GROUND AMBULANCE SERVICE LICENSURE (190.109/19 CSR 30 40.309)

	MET	NOT MET	COMMENTS
1. Vehicles meet or exceed current Federal KKK-A-1822 specifications at time of manufacture Number of vehicles on site _____ Number of vehicles checked _____	<input type="checkbox"/>	<input type="checkbox"/>	
2. Adequate no of staff, equipment, and vehicles to meet the emergency call volume needs of the service area Total calls _____ # mutual aid given _____ # of mutual aid requests received _____	<input type="checkbox"/>	<input type="checkbox"/>	
3. Availability of service (24/7/365)	<input type="checkbox"/>	<input type="checkbox"/>	
4. Staffing patterns (personnel schedules) should be available for license period	<input type="checkbox"/>	<input type="checkbox"/>	
5. Insurance – Public liability coverage for ambulance services which transport patients in the patient compartment of a vehicle shall meet or exceed: a. \$250,000 for bodily injury to, or death of, one person b. \$500,000 for bodily injury to, or death of, all persons injured or killed in any one accident, subject to a minimum of \$250,000 per person and c. \$100,000 for loss or damage to property of others in one accident excluding cargo d. Shall provide proof for license period _____ Years reviewed _____	<input type="checkbox"/>	<input type="checkbox"/>	
6. Current agreement between service and medical director Date signed _____	<input type="checkbox"/>	<input type="checkbox"/>	
(19 CSR 30-40.303)			
7. Medical Director qualifications/credentials a. Missouri State license _____ Expiration Date _____ b. Board Certification Emergency Medicine or Primary Care Specialty Expiration Date _____ c. ACLS/PALS/ATLS _____ Expiration Date _____ d. Co-medical director meet qualifications _____ Expiration Date _____	<input type="checkbox"/>	<input type="checkbox"/>	
(19 CSR 30-40.303)			
8. Medical Director and service administrator have implemented and annually reviewed: Review Date: _____ <input type="checkbox"/> Medical and treatment protocols for medical, trauma and pediatric patients <input type="checkbox"/> Triage and transport protocols <input type="checkbox"/> Protocols for DO-NOT-Resuscitate requests <input type="checkbox"/> Air ambulance utilization <input type="checkbox"/> Medications and medical equipment to be utilized	<input type="checkbox"/>	<input type="checkbox"/>	
9. Medical Control Plan – Transfer of care between agencies	<input type="checkbox"/>	<input type="checkbox"/>	
10. Communications capability Is the service able to communicate with the dispatch center, local hospitals, and trauma centers? Does the service have M-Tac/V-Tac with the local Missouri Highway Patrol	<input type="checkbox"/>	<input type="checkbox"/>	
11. List of ALS EMRAs in service area (optional) If so are Memorandum of understandings current	<input type="checkbox"/>	<input type="checkbox"/>	

(2) OPERATIONAL POLICIES AND PROCEDURES

1. Safety program including infection control program Must include comprehensive safety component	<input type="checkbox"/>	<input type="checkbox"/>	
2. Vehicle operations and driving procedures What driving program is used _____	<input type="checkbox"/>	<input type="checkbox"/>	
3. Communications procedures	<input type="checkbox"/>	<input type="checkbox"/>	
4. Standards for clinical care (medical protocols) (standing order authorization) Date Signed _____	<input type="checkbox"/>	<input type="checkbox"/>	
5. Vehicle and equipment maintenance procedures	<input type="checkbox"/>	<input type="checkbox"/>	
6. Disaster/multiple casualty protocols	<input type="checkbox"/>	<input type="checkbox"/>	
7. Quality Improvement program (including problem identification and resolution) Medical director and service administrator have implemented and annually reviewed: Review Date: _____ <input type="checkbox"/> Prolonged ambulance scene response or transport time <input type="checkbox"/> Incomplete run documentation <input type="checkbox"/> Ambulances that are diverted from their original destination <input type="checkbox"/> Skills performance <input type="checkbox"/> Compliance with adult and pediatric triage and treatment protocols <input type="checkbox"/> Any other activities the administrator or medical director deem necessary Dates for annual review: _____ Must provide examples of how program has worked	<input type="checkbox"/>	<input type="checkbox"/>	
8. (19 CSR 30-40.303) Medical director and service administrator have ensured that all licensed personnel meet education and skill competencies required for their level of license and patient care environment Date last accomplished _____ List of staff licensee numbers and expiration dates	<input type="checkbox"/>	<input type="checkbox"/>	

9. Nondiscrimination policy regarding treatment or transportation of emergency patients	<input type="checkbox"/>	<input type="checkbox"/>	
(3) RECORDS AND FORMS			
1. Ambulance run report meets required EMS data elements. What software is agency using	<input type="checkbox"/>	<input type="checkbox"/>	
2. Ground ambulance service license (excluding initial licensure)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Medical Director protocol and policy authorization	<input type="checkbox"/>	<input type="checkbox"/>	
4. Vehicle maintenance records Should have records available for license period Years reviewed _____	<input type="checkbox"/>	<input type="checkbox"/>	
5. Records of driver competency in emergency vehicle operations	<input type="checkbox"/>	<input type="checkbox"/>	
6. Equipment maintenance records Should have records available for license period Years reviewed _____	<input type="checkbox"/>	<input type="checkbox"/>	
7. Controlled substance security and record keeping	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of ambulance response times Should have records available for license period Years reviewed _____	<input type="checkbox"/>	<input type="checkbox"/>	
8. Records required by other regulatory agencies	<input type="checkbox"/>	<input type="checkbox"/>	
9. Application on file			
(4) PATIENT CARE REVIEW			
Will have available for review: <ul style="list-style-type: none"> • 10 trauma • 10 medical (non-cardiac or stroke) • 10 cardiac • 10stroke • 10 peds Areas to review: <ul style="list-style-type: none"> • Response times • Protocol compliance • Completeness of documentation 	<input type="checkbox"/>	<input type="checkbox"/>	
REMARKS			
SIGNATURE OF BUREAU OF EMERGENCY MEDICAL SERVICES REPRESENTATIVE			DATE
SIGNATURE OF AGENCY REPRESENTATIVE			DATE