



Provider _____ Provider Number _____ V.I.N. (last four if applicable) _____

Provider Address _____ City/State/Zip _____

Phone Number _____ Contact E-mail _____

Vehicle Type or Stationary Unit _____ Location/Address _____

Level of Care ALS ILS BLS FR Local ID _____ EMS System _____ Date _____

Initial Annual Self Inspection Compliant Waiver (attached)

Issue license Reinspection required (non-life threatening equipment problems)

A condition has been identified that could result in harm to the public, this vehicle should be removed from service until corrections are made, a reinspection is conducted, and IDPH approves.

Equipment

- | | |
|--|--|
| <input type="checkbox"/> Adhesive tape rolls (2) | <input type="checkbox"/> Flashlight and Pen light |
| <input type="checkbox"/> Airways - Oropharyngeal airways (adult, child, infant) | <input type="checkbox"/> Obstetrical Kit, sterile w/head cover (1) |
| <input type="checkbox"/> Airways - Nasopharyngeal airways (size 12-34 F w/lubricant) | <input type="checkbox"/> Oxygen equipment-adult, child infant masks (1 each)
Cylinder must be minimum 1200 with O2 tank key attached |
| <input type="checkbox"/> Bandages/ arm slings/triangular (2) | <input type="checkbox"/> Oxygen flowmeter/regulator for 15 lpm with delivery tubing |
| <input type="checkbox"/> Bandages/ roller, self adhering (4) | <input type="checkbox"/> Personal protective items - isolation bags (1), non-porous gloves (2), face/eye mask (2), gowns (2) |
| <input type="checkbox"/> Bandages/ sterile gauze pads (4x4) (10) | <input type="checkbox"/> Run report forms (5) |
| <input type="checkbox"/> Bandages/ Vaseline gauze (3"x 8") (1) | <input type="checkbox"/> Squeeze bag-valve-mask - adult bag with adult mask |
| <input type="checkbox"/> Bandages/ trauma/universal dressings (2) | <input type="checkbox"/> Squeeze bag-valve-mask - child, infant, and neonate mask |
| <input type="checkbox"/> Bandage scissors (1) | <input type="checkbox"/> Splinting devices (2) |
| <input type="checkbox"/> Blanket (Mylar accepted) (1) | <input type="checkbox"/> Sterile solution (1000cc) in plastic bottles or bags |
| <input type="checkbox"/> Blood pressure cuffs (adult, child, infant) w/ gauges | <input type="checkbox"/> Stethoscope (1) |
| <input type="checkbox"/> Burn Sheet (1) | <input type="checkbox"/> Suction Device with tubing and sterile single use suction catheters, one from each size range, 6 - 8; 10 - 12; 14 - 18. |
| <input type="checkbox"/> C-collars, adjustable or (1 each)-Adult Lg., Med., Sm., Child, Infant | <input type="checkbox"/> ILS/ALS system approved equipment (medication storage box, airway equipment, monitor/defibrillator) |
| <input type="checkbox"/> Cold Packs (2) and Warm packs (2) | <input type="checkbox"/> Meets temperature/environmental control standards for medication storage box. |
| <input type="checkbox"/> Communication equipment to contact hospital | |
| <input type="checkbox"/> Defibrillator/AED - w/adult and pediatric pads | |

COMMENTS:

I verify that the information provided is true and correct to the best of my knowledge. I understand that misrepresentation of this information will constitute grounds to invalidate this inspection documentation and my result in loss of EMS provider licensure.

Pre-Hospital Care Provider/Owner or Representative Signature, Title and Date

EMS System Coordinator Signature and Date

Illinois Department of Public Health Representative Signature, Title and Date