MOBILE INTENSIVE CARE UNIT
INSPECTION RECORD

INSPECTION DATE: / / APPROVED PARAMEDIC PROVIDER: YES [ ] NO [ ]

PARAMEDIC PROVIDER SERVICE:

PRIMARY BUSINESS ADDRESS:

CITY: ______________________________ ZIP CODE:

PHONE: ( ) ______ - _____________________

NAME OF OWNER(S): _______________________________ OPERATIONAL AREA:

UNIT IDENTIFICATION: __________________________ MODEL: _____________ YEAR:

LICENSE NUMBER: _______________________________ V.I.N.:

CURRENT VEHICLE REGISTRATION (ATTACH COPY): YES [ ] NO [ ]

CURRENT VEHICLE INSURANCE (ATTACH COPY): YES [ ] NO [ ]

NAME OF CARRIER: ________________________ POLICY NUMBER:

CURRENT CALIFORNIA HIGHWAY PATROL INSPECTION CERTIFICATE YES [ ] NO [ ]

AND/OR APPROVED INSPECTION SHEET (ATTACH COPY): YES [ ] NO [ ]

CURRENT MICU MEDICAL SUPPLY AND EQUIPMENT

REQUIREMENTS SATISFIED (COPY ATTACHED): YES [ ] NO [ ]

GROUND AMBULANCE SIZE, CONFIGURATION & PERFORMANCE

STANDARDS MET: YES [ ] NO [ ]

ALL PRECEDING REQUIREMENTS SATISFIED: YES [ ] NO [ ]

DISCREPANCY(IES) NOTED: YES [ ] NO [ ]

SUMMARY OF DISCREPANCY(IES):

CONCLUSION:

EMS DEPARTMENT REPRESENTATIVE NAME:

EMS DEPARTMENT REPRESENTATIVE SIGNATURE:

DATE APPROVED: / /

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