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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