

**Illinois Department of Public Health  
Division of Emergency Medical Systems and Highway Safety  
Non-transport Vehicle Inspection Form**

\_\_\_\_\_  
 Provider name Region \_\_\_\_\_ Provider number \_\_\_\_\_

\_\_\_\_\_  
 Provider address City/State/ZIP \_\_\_\_\_

\_\_\_\_\_  
 Vehicle year/Manufacturer Vehicle address V.I.N. (last four nos.)

ALS ILS B/D BLS FR/D FR / / .

Level of care (circle one) Local I.D. EMS system Date  
 Vehicle type (check one)  Engine  Pumper  Squad  Truck  Other (describe in comments section)

Vehicle class (check one)  Primary (staffed 24 hrs/7 days)  Assist (staffed as available)  
 Initial  Annual  Self-inspection  3<sup>rd</sup> party  Complaint  Other (see comment form)  Waiver (attached)

Issue license  Re-inspection required (non-life threatening equipment problems)  Advisory DO NOT OPERATE UNTIL  
 REPAIRED/REINSPECTED

**Legal action required for the following:  A condition has been identified that could result in harm to the public. This vehicle should be removed from service until all corrections are made, a re-inspection is conducted and IDPH approves (see comment form).**

**First Responder Equipment**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Triangular bandages/Arm slings              | <input type="checkbox"/> Adhesive tape rolls                                      | <input type="checkbox"/> Non-porous disposable gloves                        |
| <input type="checkbox"/> Roller bandages, self-adhering (4" X 5 yd)  | <input type="checkbox"/> Blanket  | <input type="checkbox"/> Adult squeeze bag-valve-mask                        |
| <input type="checkbox"/> Trauma/universal dressings                  | <input type="checkbox"/> OSHA personal protection items<br>(face/eye mask, gowns) | <input type="checkbox"/> Adult Oropharyngeal airways                         |
| <input type="checkbox"/> Sterile gauze pads (4" X 4")                | <input type="checkbox"/> Upper extremity splints                                  | <b>First Responder Optional Equipment</b>                                    |
| <input type="checkbox"/> Vaseline gauze/Occlusive bandages (3" X 8") | <input type="checkbox"/> Lower extremity splints                                  | <input type="checkbox"/> Stabilizing device for impaled<br>object/Tourniquet |
| <input type="checkbox"/> Bandage scissors                            | <input type="checkbox"/> Adult Oxygen equipment<br>cylinder is to be full         |  |
| <input type="checkbox"/> Automatic defibrillator                     |   |  |

**All Other Non-Transports  
(in addition to above equipment)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Oxygen flowmeter/Regulator for 15 lpm                 | <input type="checkbox"/> Adult Cervical collars                                  | <input type="checkbox"/> Cold packs  |
| <input type="checkbox"/> Delivery tubing                                       | <input type="checkbox"/> Adult Blood pressure cuffs w/gauges                     | <input type="checkbox"/> EMS run forms(Patient Care Report)                |
| <input type="checkbox"/> Nasopharyngeal airways<br>(sizes 12-30 f w/lubricant) | <input type="checkbox"/> Stethoscope   | <input type="checkbox"/> Equipment to allow communication<br>with hospital |
| <input type="checkbox"/> Manually operated suction device                      | <input type="checkbox"/> Burn sheet (individually wrapped)                       | <input type="checkbox"/> Long Backboard                                    |
|  | <input type="checkbox"/> Sterile solution (1000cc) in plastic<br>Bottles or bags |  |

COMMENTS:

As owner/representative, I agree to provide medical care in compliance with the Emergency Medical Services Act rules and regulations, 24 hours a day, every day of the year. Each vehicle will be staffed by at least two emergency medical technicians, pre-hospital R.N.s or physicians on all emergency calls. If this vehicle is operated at the intermediate or paramedic level, it will be staffed by at least one person with the appropriate license for the level of care at which the vehicle is being operated and one other emergency medical technician, pre-hospital R.N. or physician.\*I agree to provide emergency service within my service area on a per need basis without regard to a patient's ability to pay.  
 (\*State minimum requirements; EMS systems may require a higher level of staffing.)

\_\_\_\_\_  
 Pre-hospital care provider/Owner or representative signature and title Illinois Department of Public Health representative signature and title