



# CHECKLIST OF EMERGENCY VEHICLE / EQUIPMENT

State Form 51816 (R3 / 7-15)

INDIANA DEPARTMENT OF HOMELAND SECURITY

## OPERATOR / VEHICLE INFORMATION

Name of provider					Provider certification number		
Vehicle certification number		Vehicle identification number (VIN)			Date (month, day, year)		
Year	Make	Conversion	Mileage	<input type="checkbox"/> New	<input type="checkbox"/> Renewal	<input type="checkbox"/> Replacement	License plate number
Provider type <input type="checkbox"/> Transport <input type="checkbox"/> Non-transport		Level <input type="checkbox"/> Basic <input type="checkbox"/> EMT Basic-Adv. <input type="checkbox"/> Intermediate <input type="checkbox"/> Paramedic			Word AMBULANCE displayed on vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No		
Vehicle type <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> Other: _____			Certificate displayed inside vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No		Certification number on vehicle <input type="checkbox"/> Right front <input type="checkbox"/> Left front <input type="checkbox"/> Rear door		

## PHYSICAL CHARACTERISTICS

Vehicle width	Vehicle height	Patient compartment: bulkhead to litter	Litter to door	Total length	Width	Aisle	Height
Tire tread depth LF: ____ / 32    RF: ____ / 32    LR: ____ / 32    RR: ____ / 32				Communication <input type="checkbox"/> IHERN <input type="checkbox"/> Dispatch / tactical <input type="checkbox"/> UHF			

List any damage

## ENGINE, BRAKES, STEERING, ELECTRICAL

Exhaust system intact	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parking brake	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dual batteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Battery switching system	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver compartment lighting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient compartment lighting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient compartment lighting controlled by rear doors and head of litter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Audible backup warning device	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Body mounted rear light, activated by rear door	<input type="checkbox"/> Yes <input type="checkbox"/> No

## VEHICLE EXTERIOR / INTERIOR

Door seals and vents	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heating, patient compartment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheels and rims	<input type="checkbox"/> Yes <input type="checkbox"/> No	Air conditioning, driver compartment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Holding device, rear door	<input type="checkbox"/> Yes <input type="checkbox"/> No	Air conditioning, patient compartment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mirrors, right and left	<input type="checkbox"/> Yes <input type="checkbox"/> No	Windows intact	<input type="checkbox"/> Yes <input type="checkbox"/> No
Litter fasteners and restraint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appropriate wiring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seats and safety belts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sirens conform to Indiana state law	<input type="checkbox"/> Yes <input type="checkbox"/> No
Holding device, curbside door	<input type="checkbox"/> Yes <input type="checkbox"/> No	Warning lights conform to Indiana state law	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heating, driver compartment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flooring (flat, one piece vinyl or urethane quartz)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## RESCUE EQUIPMENT

Fire extinguisher, one (1) 4A;4-B;C, or two (2) 2A;4-B;C, mounted and accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No	One (1) wrecking bar, twenty-four (24) inch combination tool minimum.	<input type="checkbox"/> Yes <input type="checkbox"/> No
One (1) hammer, four (4) pound with fifteen (15) inch handle	<input type="checkbox"/> Yes <input type="checkbox"/> No	One (1) self-contained portable light source	<input type="checkbox"/> Yes <input type="checkbox"/> No

## RESPIRATORY / RESUSCITATION

Portable suction apparatus - rigid & soft tips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pocket mask with one-way valve	<input type="checkbox"/> Yes <input type="checkbox"/> No
On-board suction - rigid and soft tips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Portable oxygen equipment 300 liter with yoke, medical regulator, pressure gauge, nondependent flowmeter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bag-mask ventilation units, one (1) each: adult, child, infant, and neonatal mask only	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Oropharyngeal airway, two (2) each: adult, child, infant	<input type="checkbox"/> Yes <input type="checkbox"/> No	On-board oxygen equipment 3,000 liter with yoke, medical regulator, pressure gauge, nondependent flowmeter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasopharyngeal airway, two (2) each: small medium, large	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bulb syringe, individually packaged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen delivery devices: high concentration devices	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-visualized airway, two (2) with soluble lubricant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen delivery devices: low concentration devices	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## WOUND CARE SUPPLIES

Multiple trauma dressings, two (2), approx. 10" x 36"	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adhesive tape, two (2) rolls	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sterile gauze pads, 3" x 3" or larger, fifty (50)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burn sheets, two (2) sterile	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bandages, soft roller, self-adhering, 2" x 4 yards, four (4), minimum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Triangular bandages, four (4) minimum	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Bandage shears, one (1) pair	<input type="checkbox"/> Yes <input type="checkbox"/> No
Airtight dressings, four (4) minimum	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## PERSONAL PROTECTION / UNIVERSAL PRECAUTIONS

Gowns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biohazard bags	<input type="checkbox"/> Yes <input type="checkbox"/> No
Face masks and shields	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antimicrobial hand cleaner	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No		

# CHECKLIST OF EMERGENCY VEHICLE / EQUIPMENT *(continued)*

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Certification number
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PATIENT STABILIZATION EQUIPMENT			
Traction splint with all accessories	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Long back board with accessories, one (1)
Splinting device, one (1) unit - immobilization of head, neck, and torso with all required accessories	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rigid extrication collar, two (2) each in sizes: pediatric, small, medium, large
Upper & lower splinting device, two (2) each	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Litter with side rails, mattress pad, three (3) restraints
MISCELLANEOUS ITEMS			
Obstetrical kit, one (1), sterile	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stethoscopes, one (1) each in sizes: adult, pediatric
Clean linens - pillow, pillow case, sheets, blankets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	One (1) sharps collector (7" in height)
Blood pressure manometer, one (1) each in cuff sizes: large adult, adult, pediatric	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Basic life support protocols on board
EMT BASIC - ADVANCED SUPPLIES			
IV fluids & administration supplies approved by MD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	List of IV fluids and administration sets, quantities
Advanced life support protocols on board	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
INTERMEDIATE - PARAMEDIC SUPPLIES			
Tracheal suction catheters - sizes 10, 14, 18	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Advanced life support protocols on board
Endotracheal intubation devices including: laryngoscope with extra batteries and bulbs; blades, adult and pediatric, curved and straight; tubes, two (2) each, sizes 3-9	<input type="checkbox"/> Yes	<input type="checkbox"/> No	List of medications, including quantities and concentrations approved by medical director
			Narcotics in double locked box.
IV fluids, medication, and administration supplies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
MEDICATIONS / BLS IF APPROVED BY MEDICAL DIRECTOR			
<div style="border-top: 1px dashed black; border-bottom: 1px dashed black; min-height: 40px;"></div>			
DEFIBRILLATION SUPPLIES			
Monitor defibrillator <input type="checkbox"/> Manual <input type="checkbox"/> Semi-automatic <input type="checkbox"/> Automatic	Make		Model
Pads, adult	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Paddles, adult
Pads, pediatric (intermediate - paramedic only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Paddles, pediatric (intermediate - paramedic only)
INSPECTION STATUS			
Send written verification to District Manager within ten (10) days of this inspection _____ <input type="checkbox"/> Vehicle not to be used until re-inspected.			
COMMENTS			
<div style="border-top: 1px dashed black; border-bottom: 1px dashed black; min-height: 150px;"></div>			

Signature of provider representative	Title	Date (month, day, year)
Signature of EMS Commission representative		Date (month, day, year)