

**Illinois Department of Public Health  
Division of Emergency Medical Services 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  Reinspection 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 reinspection 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 with adult and child mask  |
| <input type="checkbox"/> Trauma/universal dressings                             | <input type="checkbox"/> Isolation bag                                                                       | <input type="checkbox"/> Child squeeze bag-valve-mask with child and infant mask |
| <input type="checkbox"/> Sterile gauze pads (4" X 4")                           | <input type="checkbox"/> OSHA personal protection items (face/eye mask, gowns)                               | <input type="checkbox"/> Oropharyngeal airways (adult, child, infant)            |
| <input type="checkbox"/> Vaseline gauze/Occlusive bandages (3" X 8")            | <input type="checkbox"/> Upper extremity splints                                                             | <input type="checkbox"/> Pediatric lower extremity splints                       |
| <input type="checkbox"/> Bandage scissors                                       | <input type="checkbox"/> Lower extremity splints                                                             |                                                                                  |
| <input type="checkbox"/> Automatic defibrillator (requires EMS system approval) | <input type="checkbox"/> Oxygen equipment with adult, child, infant masks (one each); cylinder is to be full | <b>First Responder Optional Equipment</b>                                        |

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

- |                                                                             |                                                                                  |                                                                                                                |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Oxygen flowmeter/Regulator for 15 lpm              | <input type="checkbox"/> Cervical collars (adult, child, infant, peds)           | <input type="checkbox"/> Obstetrical kit, sterile with head cover                                              |
| <input type="checkbox"/> Delivery tubing                                    | <input type="checkbox"/> Blood pressure cuffs (adult, child, infant) with gauges | <input type="checkbox"/> Cold packs                                                                            |
| <input type="checkbox"/> Nasopharyngeal airways (sizes 12-30 f w/lubricant) | <input type="checkbox"/> Stethoscope                                             | <input type="checkbox"/> EMS run forms                                                                         |
| <input type="checkbox"/> Manually operated suction device (IDPH approved)   | <input type="checkbox"/> Burn sheet (individually wrapped)                       | <input type="checkbox"/> Equipment to allow communication with hospital                                        |
| <input type="checkbox"/> Flashlight                                         | <input type="checkbox"/> Sterile solution (1000cc) in plastic bottles or bags    | <input type="checkbox"/> ILS/ALS system approved equipment (drug box, airway equipment, monitor/defibrillator) |
| <input type="checkbox"/> Long backboard                                     |                                                                                  |                                                                                                                |

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 \_\_\_\_\_