Molina 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name	Origin of Services
ID # of Recipient	Destination
Date of transport	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:
Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable and is not likely to require the attendance of an EMT. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: Patient will require transportation _____ (number) times a week during the month's _____, _____ (month(s). (year)) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months).
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en Route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:
Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other *(describe):*

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

I have read the above certification and I have read and understand the instructions on the reverse side of this form.	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reasons:

X **Signature of MD/PA/NP/CNS/RN/DON** _____ **Printed Name** _____ **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form. Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Molina Form 105. Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services. If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate.

Molina 105 ATTACHMENT-INSTRUCTIONS

CERTIFICATION OF AMBULANCE TRANSPORTATION

Purpose
Molina 105 Attachment is initiated to support medical necessity for ambulance transportation for those recipients residing in nursing facilities or those recipients receiving dialysis, radiology and physical therapy services. Facility reviewers will review this form to determine whether the facility is properly requesting ambulance transportation services. Ambulance transportation reviewers will review this information to determine the patient's condition meets the need for ambulance transportation.

Preparation
Identifying Information: Recipient name, Medicaid ID number, date of transport, origin of service, destination, and destination address shall be completed by either the ambulance transportation provider or the facility. Every item is to be completed.

Certification of Ambulance Transportation Necessity (Section I): Effective with date of service July 1, 2003, the Department of Health and Hospitals has revised the certification form (Form 105 Attachment). The new form shall replace the Form 105 Attachment 1 currently in use by the ambulance industry. Also, the certification shall require the attending physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse (all applicable sate licensure or certification requirement must be met) or nursing facility director of nursing for LTC residents to certify that the patient's condition meets the need for ambulance transportation services. Ambulance transportation was necessary because other means of transportation would endanger the life or health of the patient. In addition, signed certification statements from physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), registered nurses (RN), or nursing facility director of nursing for LTC residents are also acceptable when professional services are furnished by the same.

Type of Ambulance Transportation Necessary:
There are three types of medical transport available:

1. Emergency ambulance transport is appropriate in case of accidents or sudden medical emergency.
2. Non-emergency ambulance transport is to be utilized when the condition of the patient requires or may require medical care en route. Examples of conditions which could reasonably be expected to require non-emergency ambulance transport are: (1) unstable diabetes; (2) chronic pulmonary diseases requiring use of oxygen during transport; (3) unstable ventilator assistance; (4) IV therapy. Prior scheduling is to be utilized.
3. Non-emergency, non-ambulance transport is appropriate for routine non-emergency transport of wheelchair or ambulatory patients. Prior scheduling is to be utilized.

Medical Professional Statement (To Be Completed by MD/PA/NP/CNS/RN/DON)-(Section II): The Medical Professional Statement section is to be completed only if the recipient's physician has not issued written orders requiring ambulance transportation. Such written orders, if used in lieu of the Medical Professional Statement on this form, must specify the medical condition which requires travel by ambulance, the length of time for which ambulance transport will be necessary, and must be signed and dated by the physician. A copy of the written orders, if pertinent, must be attached to the form.

If no written orders have been issued, the Medical Professional Statement shall be completed by the treating medical doctor, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or the nursing facility director of nursing. (The physician may be the physician treating the patient, the physician who instructed the patient to travel to the medical facility, or the medical director of the facility which received the patient.) The medical professional shall check the appropriate block indicating agreement with the facility statements or indicating disagreement and the reason for disagreement.

Ambulance Driver and Attendant Designation and Signature: The names of the ambulance driver and attendant and their national EMT numbers shall be printed or typed legibly by the transportation provider. The form MUST be signed and dated by the driver and the attendant.

Disposition
The facility may file a copy of the form in the patient's record when transport is provided. In cases involving nursing facilities, this copy shall be completed, signed, and dated by the nursing facility Director of Nursing, the ambulance driver, and the ambulance attendant. The Medical Professional Statement shall also be completed unless the medical professional at the medical destination is to complete this section.

Ambulance transportation providers who submit paper claims or bill electronically shall retain the original of the form in the office available for review for a period of five (5) years from the date of service. Every claim shall have either a copy of the physician's written orders attached or the Medical Professional Statement on the form completed, signed, and dated by the appropriate medical professional.

NOTE: When the Medical Professional Statement disagrees with the certification of medical necessity, non-emergency ambulance transport shall be reimbursed at a rate not to exceed the non-emergency, non-ambulance rate.

Form MT-3 (Revised 12/93)

DATE OF TRANSPORTATION ___/___/___
TIME OF APPOINTMENT _____ a.m./p.m.

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name_____

Recipient Name_____ ID #_____

Recipient Address_____
Street City State Zip

Having no other form of transportation to receive medical treatment under the Medicaid Program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for verification that I have kept my medical appointment.

_____ _____
Signature Date

II. DRIVER CERTIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

_____ _____
Signature Date

☐ I certify that I was the driver who provided transportation for the above named recipient from the medical facility to the recipient's home.

_____ _____
Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on ___/___/___ at _____ a.m./p.m. and received medical service.

☐ I certify that the above named recipient was in the office on ___/___/___ at _____ a.m./p.m. but did not receive medical services because_____
_____
_____

Provider Office Stamp

_____ _____
Signature and Title Date

FORM MT-3 AND INSTRUCTIONS FOR COMPLETION

The MT-3 provides verification that a medical appointment was kept. It is completed by the driver and signed by the recipient and the medical provider or representative to confirm that the trip was completed. If the recipient does not or will not sign the MT-3, an explanation must be given in the "remarks" section of the claim form (Form 106). Following are instructions for completion of the Form MT-3 and a sample MT-3 form.

Top Section of MT-3 Form:

Date of Transportation: complete space provided with the date the transportation is being provided.

Time of Appointment: complete space provided with the actual time of the medical appointment. Circle a.m. or p.m. as appropriate.

I. Recipient Verification of Medical Transportation

Transportation Provider Name: complete with provider's name.
Recipient's Name: complete with recipient's name as it appears on the medical eligibility card.
Recipient's ID #: complete with the recipient's 13-digit ID number.
Recipient's Address: complete with the recipient's complete address including zip code.

Signature and Date: the recipient must sign and date with that day's date. If the recipient signs with a mark, this mark must be witnessed by at least one person who can sign his/her name.

II. Driver Certification

The driver of the vehicle should sign and date the form, providing the name of the driver who picked up the recipient for the appointment and returned the recipient after the appointment.

III. Medical Service Provider Verification

The medical provider or his/her representative must complete section III.

If the recipient did not receive medical services, an explanation is required.

An office stamp is accepted, but the medical provider or his/her representative must also sign and give his/her title and date.

The MT-3 form may not be signed prior to the service being rendered.

The form should be returned to the transportation provider. Further information on the use of this form can be found in Section 7 of the Medicaid Transportation Services provider manual (issued January 20, 1998).

Form HSS-MT-8 (revised 2/99)

DRIVER INFORMATION FORM

1. Provider's Name_____ 2. Provider Number_____

3. Driver's Name _____ 4. SS# ____ - _____ - _____
Last First M.I.

5. Maiden Name (if applicable) _____ 6. Start Date ____/____/____

7. Driver's Address _____
Street City State Zip

8. Driver's Telephone # (___)_____ 9. Driver's Chauffeur License: a. License #_____
b. issue Date ___/___/___ c. DOB ___/___/___ d. Class _____ e. State ____
f. Expiration Date ___/___/___ g. Sex ____ h. Race _____
i. Does license have any restrictions? Y/N If yes, indicate what the restrictions are:

_____

_____

10. Has license ever been suspended or revoked? Y/N If yes, explain:

_____

_____

_____

11. Has driver had experience transporting people commercially? Y/N
If yes, how many years? _____ With whom? _____

12. Has driver ever worked for a NEMT company? Y/N If yes, which company and how long?

_____

13. List the date driver had National Safety Council's Defensive Driving course.
Date of course ___/___/___

14. Has driver eve been convicted of a traffic related offense in the past 10 years? Y/N
If yes, list offense(s) and date with an explanation:

_____

15. Has driver ever been involved in any accident which involved a fatality? Y/N If yes, explain:

_____

16. Has driver ever been on probation or sentenced to jail/prison as a result of a felony conviction or guilty plea? Y/N
If yes, attach a separate sheet giving the law enforcement authority (city police, sheriff, FBI, etc.), the offense, date of offense, place, and disposition of case.

Your signature on this form is attesting to the validity of this information.

Driver's Signature: _____ Date:___/___/___

Provider's Signature: _____ Date:___/___/___

Form HSS-MT-8-C (revised 2/99)

DRIVER'S CHANGE FORM

Provider Information

1. Provider Name_____ 2. Telephone Number (__)_____

3. Provider Number _____ 4. FAX Number (__)_____

5. Address_____
Street City State Zip

Driver Information

6. Driver's Name_____ 7. DOB ___/___/___ 8. SSN# ___-___-___

9. Address_____
Street City State Zip

10. Type of Change
a. ☐ **Termination**
☐ Voluntary
☐ Involuntary

Reason_____

_____

b. ☐ Modify
☐ Change of Address

From_____
Street City State Zip

To_____
Street City State Zip

☐ *Change of Name*

From_____

To_____

☐ *Change in Class of License*
Copy of new license attached? Circle Y/N

☐ Other _____

_____

Your signature on this form is attesting to the validity of this information.

Driver's Signature: _____ Date:___/___/___

Provider's Signature: _____ Date:___/___/___

HSS-MT-9 (Revised 9/03)

HEALTH STANDARDS SECTION

TRANSPORTATION VEHICLE INSPECTION FORM

I. GENERAL INFORMATION (to be completed by provider)

PARISH:	**UNIT NUMBER:**
PROVIDER NAME:	**VIN:**
PROVIDER NUMBER:	**MAKE:**
PROVIDER'S TELEPHONE # ( )	**YEAR:** **COLOR:**
REGISTRATION NAME:	**MODEL:**
STREET ADDRESS:	**LICENSE PLATE NUMBER:**
CITY/STATE/ZIP:	**LICENSE PLATE EXPIRATION:**

II. TYPE OF INSPECTION (to be completed by the INSPECTOR)

☐ INITIAL ☐ ANNUAL ☐ SPOT CHECK ☐ CHOW

☐ FLEET ADDITION ☐ REINSPECT 1 ☐ REINSPECT 2

III. VEHICLE INFORMATION (to be completed by the INSPECTOR)

MVI# **ODOMETER READING:**	**PROOF OF INSURANCE:** **YES NO**	**INSURANCE. EXPIRATION DATE:** **____/____/____**
STICKER EXPIRES: **_____/_____**	**VEHICLE CAPACITY:** **Passenger _____W/C__**	**TOTAL DAILY VEHICLE CAPACITY:** **Passenger _____ W/C __**

IV. VEHICLE INSPECTION (to be completed by the INSPECTOR)

See attached HSS-MT-9b

V. RESULTS OF INSPECTION (to be completed by the INSPECTOR)

☐ UNIT PASSED INSPECTION.

DECAL NUMBER: _____ EXPIRES: ___/___/___

☐ UNIT FAILED INSPECTION. PROVIDER MAY REQUEST RE-INSPECTION WHEN CORRECTIONS HAVE BEEN MADE.

PROVIDERS SIGNATURE **DATE** **INSPECTOR SIGNATURE**

INSPECTION OF VEHICLE (to be completed by the inspector) *DENOTE OPTIONAL SERVICES

VIN #_____

ITEM	PASS	FAIL	COMMENTS	REINSPECT		REINSPECT	
				PASS	FAIL	PASS	FAIL
A1 & 2 BODY & DAMAGE							
A3 PROPERLY MARKED							
A4 TIRES							
A5 LIGHTS							
A6 MIRRORS							
A7 WINDSHEILD							
A8 WIPERS/WASHERS							
A9 WINDOWS/DOORS							
B1 INTERIOR							
B2 HEATER							
B3 AIR CONDITIONER							
B4 HORN							
B5 SEAT BELTS							
B6 EXHAUST							
C1 FIRE EXTINGUISHER							
C2 FIRST AID KIT							
C3 HIV KIT							
C4 CHILD SEAT							
C5 JACK/SPARE							
D1 WHEELCHAIR LIFT M/H*							
D2 WHEELCHAIR RAMP/TOE*							
D3 WHEELCHAIR RESTRAINTS – TYPE*							
D4 TWO WAY RADIO* SYSTEM (HANDICAP V)							

COMMENTS: _____

_____

_____

SURVEYOR: _____

INSTRUCTIONS FOR FORM MT-9

Form MT-9, the Vehicle Inspection Form, must be completed as follows:

I. **The Provider** must complete the following items in the first section of this form:

- Parish in which the vehicle is stationed
- Provider's name
- Provider number – if the service is new, write "new" in the space provided
- Provider's telephone number – including area code
- The registration (business) name – this name must also be on the Louisiana Certificate of registration;
- Street address of the business, including the city, state, and zip code;
- Unit number – the number that you assign to the vehicle for tracking purposes;
- VIN (vehicle identification number);
- Make of the vehicle;
- Color of the vehicle;
- Model of the vehicle; and
- License plate number and expiration date.

Note: No vehicle will be inspected without the above completed prior to the inspection.

II. Completed by the Inspector

The remainder of this form is completed by the inspector during the inspection of the vehicle. Details of this inspection can be found in Section 7 on Monitoring and Documentation of provider manual*. After completion of the form, the inspector will have the driver or transportation company representative sign and date the form. Then, the inspector will sign and date the form.

If the vehicle has passed the inspection, the inspector will write the vehicle's decal number in the appropriate space on the form.

The inspector should ensure that the form is readable and give a copy to the driver/company representative.

*Section 7, Documentation and Monitoring, of the provider manual has been included in this enrollment packet following the HSS-MT-9b form.

NEMT REQUEST FOR INSPECTION (Fleet Addition)

TO: HEALTH STANDARDS NEMT PROGRAM DESK
via fax @ 225-342-5292; or mail to ;
Post Office Box 3767
Baton Rouge, Louisiana 70821-3767

COMPLETE ALL NECESSARY BLANKS:

Date of Request: _____/_____/_____ Unit Number: _____

Provider Name: _____ Provider Number: _____

Provider Address: _____

City, State, Zip: _____

Telephone: _____ Fax Number: _____

Contact Person: _____

Reason for Inspection:

_____ Additional Vehicle VIN: _____

_____ Replacement Vehicle VIN: _____

Replacing Unit Number: _____ VIN: _____

_____ Windshield Replacement _____ Other

This vehicle will be ready for inspection on (date): _____

This form must be accompanied by the:

1. Certificate of Registration indicating that it has the appropriate license plate (hire, taxi, hire bus, or public)
2. Certificate of Insurance listing the vehicle by physical description and VIN indicating the vehicle has been placed on your NEMT fleet automobile liability policy.
3. A MT-9 form with Section I completed.

Your Health Standards Regional Office will contact you and schedule an inspection.

HSS-MT-15 (8/4/99)

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

INSTRUCTIONS FOR COMPLETING NEMT REQUEST FOR INSPECTION (FLEET ADDITION) FORM (HSS-MT-15)

This form is to be used to add vehicles to your fleet. All additions to your fleet, whether permanent or temporary must be reported to the Department and permitted for use prior to the vehicle being used to transport Medicaid clients. Please keep copies of this form and these instructions in your files at all times. Feel free to copy the form.

Fill in all blanks on the form with the appropriate information, and attach the following documents:

1. The Certificate of Registration from the Louisiana Office of Motor Vehicles

2. A copy of your current insurance certificate showing the Vehicle Identification Number of the new vehicle added to your policy. Your insurance agent must follow this up with an original Certificate of Insurance showing that the new vehicle has been added to your policy.

We do not accept Louisiana Automobile Insurance Identification cards.

3. A NEMT Vehicle Inspection Form (HSS-MT-9A) with Section 1 completed. Fax this form and the required attachments to the Health Standards NEMT Program Desk at 225-342-0157. All documents are to be faxed to this office at the same time. Keep the originals and give them to the surveyor when he or inspects your vehicle.

A temporary permit will be faxed to you within two working days receipt of your vehicle information. Complete this permit, sign it, and fax it to this office at the telephone number listed above. I will review the information, sign the permit, and fax it back to you. You may now use the vehicle until it is inspected. Keep a copy of the permit in the vehicle at all times.

Please note: A copy of the Louisiana Public Service Commission Form MT-10 (Affidavit) has been included. If you do not have a "For Hire" waiver from the Louisiana Public Service Commission, you will need to complete this form and submit it to them for approval. Once you receive the waiver back from them, you must submit it to the Office of Motor Vehicles in order to obtain your "For Hire" license plate.

If you need additional information, you may contact the NEMT Program Desk at 225-342-9404.

500 Laurel Street • Suite 100 (70801-1811) • P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

REQUEST FOR INSPECTION – (Ambulance–Sprint–Air Ambulance)

FAX TO: (225)-342-5292 or
MAIL TO: Health Standards Section
Attn: Emergency Medical Transportation Program Manager
P.O. Box 3767
Baton Rouge, La. 70821-3767

SERVICE: _____

UNIT LOCATED: _____

REQUESTED BY: _____

PHONE NUMBER: (_____) _____-_____

REASON FOR INSPECTION: (Circle One Below)

– New Unit Addition to Existing Fleet VIN# _____

– New Unit Replacing Unit # _____ VIN# _____

Decal # _____

New VIN # _____

– Windshield Replacement or Other Re-Inspection Old Decal # _____

(Circle if applicable)

-- This unit is ready for inspection NOW.

-- This unit will be ready for inspection on _____/_____/_____

Is this an emergency replacement of a downed vehicle? _____

Office Use Only:

DECAL # _____ **UNIT #** _____

DATE APPLIED: ___/___/___ **REQUESTED:** _____

****This form must be accompanied by a Certificate of Insurance and a Certificate of Registration for the Vehicle and a Vehicle Inspection Fee of $75.00 per vehicle. Payment may be made in the form of a company check or money order payable to the Department of Health & Hospitals.*** ***

HSS-ET-05 (revised 05/09)

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

INSTRUCTIONS FOR COMPLETING EMS REQUEST FOR INSPECTION (FLEET ADDITION) FORM (HSS-ET-05)

This form is to be used to add vehicles to your fleet. All additions to your fleet, whether permanent or temporary must be reported to the Department and permitted for use prior to the vehicle being used to run calls and transport patients. You may do this paperwork as soon as you receive the VIN from the dealer or manufacturer. You do not have to take delivery on the vehicle to report it to the Department.

Please keep copies of this form and these instructions in your files at all times. Feel free to copy the form as needed.

Fill in all blanks on the form with the appropriate information, and attach the following documents:

1. The Certificate of Registration from the Louisiana Office of Motor Vehicles
2. A copy of your current insurance certificate showing the Vehicle Identification Number of the new vehicle added to your policy faxed to us by your insurance agent.

We do not accept Louisiana Automobile Insurance Identification cards.

(Note: this list of required attachments is also on the fleet addition form.)

Fax this form and the required attachments to the Health Standards EMS Program Desk at 225-342-0157. All documents are to be faxed to this office at the same time.

At the same time, mail an agency check or money to the Health Standards EMS Program Desk at the address on the bottom of the page.

Put a copy of the completed "Request for Inspection Form" in the vehicle. This will serve as your temporary permit. Keep a copy of the permit in the vehicle at all times.

You may use the vehicle once the Department has received your check.

If you need additional information, you may contact the NEMT Program Desk at 225-342-9404.

500 Laurel Street • Suite 100 (70801-1811) • P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Company Name:

Non-Emergency Medical Transportation Log

Name/Medicaid ID#	*Address (include city)*	*Destination (include city)*	*Departure time*	*Arrival time*	*Driver's Name*	*Comments*

MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

AMBULANCES

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number													
UNIT #s→														
1. TWO-WAY RADIO/DAY TO DAY COMMUNICATION:														
Must have a national standard public safety two-way radio communication (day-to-day communications). The ambulance dispatch center(s) and/or point(s) of dispatch must be capable of interactive two-way communications within all of the service's defined area.														
2. TWO-WAY RADIO/DISASTER COMMUNICATION CAPABILITY:														
Two-way radio with disaster communications capability- VHF –National EMS Mutual Aid Frequency, V-Med 28, also known as the HEAR system 155.34 0 Mhz; with carrier squelch, ENCODER optional.														
3. DIRECT COMMUNICATION with a PHYSICIAN and HOSPITAL:														
Must be conducted through: HEAR; wireless telephone; RTSS; or Med. 10 System, etc...;														
4. All ambulances must carry the following BASIC MEDICAL SUPPLIES and EQUIPMENT:														
4a. one suction unit capable of providing a suction of at least 300 mm Hg;														
4b. two wide bore tubing;														
4c. two rigid pharyngeal tonsilar wide bore tip;														
4d. a second suction unit that is portable;														
4e. two each suction liners or refills, if required;														
4f. two suction catheters, 5 fr, or 6 fr, or 5/6 fr;														
4g. two suction catheters, 14 fr or larger;														
4h. one portable oxygen cylinder, at least 500 psi, 2000 psi full, appropriate color;														
4i. one portable oxygen regulator/flowmeter, variable flow;														
4j. one fixed oxygen cylinder, "M" or "O" cylinder, at least 500 psi, 2000 psi full, appropriate color or equivalent;														

Page **1** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french **RTSS**=Radio Telephone Switch Station **AED**=Automated External Defibrillator **Laryngoscopes** - reusable or disposable

*= or alternative medication approved by appropriate parish/component medical society **pm** = pre-mixed

MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
AMBULANCES
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number														
UNIT #s→															
4k. one fixed oxygen regulator, variable flow;															
4l. one oxygen wrench;															
4m. one fixed oxygen flowmeter;															
4n. one humidifier;															
4o. four adult non-rebreather masks;															
4p. four pediatric non-rebreather masks;															
4q. four adult nasal prongs with supply tubing;															
4r. two adult BVM with reservoir and supply tubing;															
4s. two pediatric BVM with reservoir, & supply tubing & infant mask;															
4t. two oral airways, adult;															
4u. two oral airways, child;															
4v. two oral airways, infant;															
4w. one traction splint with ratchet, straps, and ankle hitch, adult;															
4x. two extremity splints, upper;															
4y. two extremity splints, lower;															
4z. three extrication-type cervical collars, adult; *(adjustable collars may be used)*															
4aa. three extrication-type cervical collars-pediatric; *(adjustable collars may be used)*															
4bb. three cervical immobilization devices;															
4cc. three long spine immobilization device with at least 3 points of confinement (one must be a clamshell device);															
4dd. one short spine immobilization device with appropriate straps and pillows;															
4ee. two burn sheets, sterile;															
4ff. fifty small sterile dressings, 4" x 4"(at least 25 packs of 2);															
4gg. ten large combine dressings, sterile, 5" x 9" or larger;															
4hh. two multi-trauma dressings, 10" x 30" or larger or 18" x 24" military abdominal dressings;															

Page **2** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french **RTSS**=Radio Telephone Switch Station **AED**=Automated External Defibrillator **Laryngoscopes** - reusable or disposable

*= or alternative medication approved by appropriate parish/component medical society **pm** = pre-mixed

MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
AMBULANCES
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number													
UNIT #s→														
4ii. eight triangle bandages, commercial;														
4jj. ten soft roller bandages, 2" wide, unused rolls;														
4kk. six rolls of hypoallergenic adhesive tape, 1" and 2" or wider (no paper tape);														
4ll. two occlusive dressings, 3" x 8" or larger petroleum gauze or commercial chest seal;														
4mm. four chemical cold packs;														
4nn. two liters normal saline for irrigation in plastic containers;														
4oo. sterile water, 500 cc or larger in plastic container;														
4pp. oral glucose, 12.5 mg (cake icing may be (substituted);														
4qq. one aspirin 325 mg (5 grain) or four aspirin, 81 grain pediatric;														
4rr. one albuterol inhalation solution, 2.5 mg with appropriate delivery device;														
4ss. three per crew member Mark I kits (0.7 mg atropine and 2 PAM-VO) or one Duodote kit per crew member, per vehicle														
4ww. one OB kit;														
4xx. one roll of aluminum foil or a silver swaddler;														
4yy. one blood pressure cuff, adult;														
4zz. one blood pressure cuff, pediatric;														
4aaa. one stethoscope;														
4bbb.one pair trauma shears;														
4ccc. one set of three triangle reflectors (or cyalume light sticks, or traffic cones), set;														
4ddd. two flashlights, minimum of 2 "C" cell size with spare batteries and bulbs;														
4eee. twenty-five triage tags; and														
4fff. one supra glottic airway approved by the Louisiana EMS Certification Commission.														
5. INFECTION CONTROL SUPPLIES & EQUIPMENT														
5a. one box of non sterile exam gloves;														

Page **3** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french
RTSS=Radio Telephone Switch Station **AED**=Automated External Defibrillator **Laryngoscopes** - reusable or disposable
*= or alternative medication approved by appropriate parish/component medical society **pm** = pre-mixed

MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

AMBULANCES

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number														
UNIT #s→															
5b. one box of gloves, non latex;															
5c. two pair of full peripheral glasses with face mask or fluid shields															
5d. one per crew member jumpsuit/gown, impervious to liquid, disposable;															
5e. two readily identifiable trash bags, labeled for contaminated wastes;															
5f. one pair per crew member shoe covers;															
5g. one sharps container, 1 quart;															
5h. one bottle or 12 towelettes of commercial antimicrobial hand cleaner;															
5i. two biohazard trash bags;															
5j. four N-95 masks;															
5k. one set per crew member, chemical resistant, full body coverage coverall with hood;															
5l. one pair per crew member, chemical resistant footwear;															
5m.one roll per crew member, chemical sealant tape (not duct tape);															
5n. one pair per crew member, chemical resistant goggle with a minimum of a N-95 mask.															
6. All AMBULANCES MUST BE EQUIPPED WITH the following:															
6a. two fire extinguishers, 2:-10:B:C; *(dry chemical ABC or CO^2, no halon)*															
6b. two blankets;															
6c. one current US DOT Hazardous Materials Guidebook;															
6d. one set per crew member, hard hat and safety goggles (ANZI 37.1 or NFPA approved fire fighter turn out gear);															
6e. one pair per crew member, leather or nomex gauntlet gloves;															
6f. one per crew member, incident command vest with florescent trim and appropriate logos;															

Page **4** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
AMBULANCES
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number														
UNIT #s→															
6g. one stretcher, wheeled, multi-level;															
6h. one set of stretcher straps with a least three points of confinement, including shoulder harness; and															
6i. **ALL AMBULANCES that are not staffed and equipped to the EMT PARAMEDIC LEVEL MUST CARRY:**															
6i.-i. one AED with electrodes and leads; - *(as described in 7a. - an AED (either automatic or semi-automatic) with the appropriate lead cables and at least two set of the appropriate disposable electrodes. If the AED is also capable of manual defibrillation, then an appropriate lock-out mechanism (such as an access code, computer chip, or lock and key) to prevent unauthorized use of the device by those persons not authorized to manually defibrillate must be an integral part of the device);*															
6i.-ii. One epinephrine auto injector adult, 0.30 mg; and															
6i.-iii. One epinephrine auto injector, pediatric, 0.15 mg.															
7. The following must be carried by all AMBULANCES STAFFED & EQUIPPED to the EMT INTERMEDIATE & PARAMEDIC LEVEL															
7b. two bags of IV fluids for KVO lines, D5W or isotonic 0.9 percent NaCl, 250 cc bag minimum;															
7b-i. all IV fluids must be in plastic bags or bottles, not glass bottles, unless medically indicated otherwise;															
7c. 4,000 cc IV fluids for volume expansion, Ringers' Lactate or 0.9% isotonic NaCl (these bags of saline do not include the bags or															

Page **5** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french
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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

AMBULANCES

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number													
UNIT #s→														
bottles of saline above for irrigation purposes;														
7c.-i. all IV fluids must be in plastic bags or bottles, not glass bottles, unless medically indicated otherwise;														
7d. four sets of minidrip tubing;														
7e. four sets of macrodrip tubing;														
7f. one set of Y-type blood tubing;														
7g. two extension tubings;														
7h. one three-way stop cock;														
7i. four over-the-needle IV catheters, 14 gauge;														
7j. four over-the-needle IV catheters, 16 gauge;														
7k. four over-the-needle IV catheters, 18 gauge;														
7l. four over-the-needle IV catheters, 20 gauge;														
7m. four over-the-needle IV catheters, 22 gauge;														
7n. two venous tourniquets;														
7o. two syringes, 1 cc w/ 0.1cc graduations;														
7p. two syringes, 3 cc to 6 cc;														
7q. two syringes, 10 cc to 12 cc;														
7r. two syringes, 30 cc w/ leur lock														
7s. two hypodermic needles, 21 to 23 gauge;														
7t. two hypodermic needles, 25 to 27 gauge;														
7u. one EPA or OSHA approved sharps container for use at the patient's side;														
7v. ten antiseptic solution wipes;														
7w. one IV pole or roof hook;														
7x. three IV arm boards of various sizes; and														
8. <u>The following must be carried by all PARAMEDIC LEVEL AMBULANCES:</u>														
8a. two intra osseus needles of preference;														
8b. one Magill forceps, adult;														
8c. one Magill forceps, pediatric;														
8d. one tube or five packets of water soluble lubricant not containing cellulose;														
8e. two endotracheal tubes, uncuffed, 3.0 to 3.5;														
8f. two endotracheal tubes, uncuffed, 4.0 to 4.5;														
8g. two endotracheal tubes, uncuffed, 5.0 to 5.5;														

Page **6** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

<u>NOTE:</u> **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french
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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

AMBULANCES

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number														
UNIT #s→															
8h. two endotracheal tubes, cuffed, 6.0 to 6.5;															
8i. two endotracheal tubes, cuffed, 7.0 to 7.5;															
8j. two endotracheal tubes, cuffed, 8.0 to 8.5;															
8k. two stylettes, adult;															
8l. two stylettes, pediatric;															
8m. one laryngoscope handle w/ 1 set of spare batteries and bulbs, or two disposable handle units;															
8n. one laryngoscope blade, Size 0, straight, or two disposable blades, Size 0, straight;															
8o. one laryngoscope blade, Size 1, straight, or two disposable blades, Size 1, straight;															
8p. one laryngoscope blade, Size 2, straight, or two disposable blades, Size 2, straight;															
8q. one laryngoscope blade, Size 3, straight or curved, or two disposable blades, Size 3, straight or curved;															
8r. one laryngoscope blade, Size 4, straight or curved, or two disposable blades, Size 4, straight or curved;															
8s. one cardiac monitor defibrillator with paper strip recorder;															
8t. two sets defib pads or gel;															
8u. one set of lead cables;															
8v. two sets of disposable monitoring electrodes;															
8w. one glucometer, CLIA approved;															
8x. two end tidal CO^2 detection or monitoring devices;															
8y. ANALGESIC:															
8y.-i. one aspirin 5 grain or four 81 mg;															
8y.-ii. Morphine*, 10 mg/ml;															
8z. ANTI-ARRHYTHMIC:															
8z.-i. five Adenosine, 6 mg;															
8z.-ii. four Atropine, pf, 1 mg;															
8z.-iii. one Calcium Chloride, 10%, 1 gram;															

Page **7** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

AMBULANCES

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6057B. Medical and Safety Equipment	BLS/ILS/ALS & Unit Number														
UNIT #s→															
8z.-iv. three Amiodorone pf, 150 mg or four Lidocaine 100 mg pf bolus;															
8z.-v. one Lidocaine, 1 gram; may be premixed															
8aa. ANTI-CONVULSIVE:															
8aa.-i. one Valium*, 10 mg/2 ml;															
8aa.-ii. Two Mag Sulfate, 2 grams;															
8bb. ANTI-HISTAMINE:															
8bb-i. one Benadryl, 50 mg;															
8cc. BRONCHODILATORS:															
8cc-i. one Albuterol, 2.5 mg *;															
8dd. **CARDIO-VASCULAR:**															
8dd-i. two Dopamine, 200 mg (may be pm);															
8dd-ii. three NTG, 0.4 mg Tablet or spray;															
8ee. **DIABETIC CONTROL:**															
8ee-i. two D50W, 50 cc;															
8ee-ii. two Glucagon, 1 mg;															
8ff. **LOOP DIURECTIC:**															
8ff-i. one Bumex 2 mg; or two Lasix, 80 mg;															
8gg. **NARCOTIC ANTAGONIST:**															
8gg-i. Naloxone, 2 mg;															
8hh. **VASOPRESSORS, 12 mg total:**															
8hh-i. at least two Epinephrine, 1 mg 1:1000;															
8hh-ii. at least two Epinephrine, 1 mg 1:10000; and															
8hh-iii. Vasopressin, 1 mg (optional)															

SURVEYOR NOTES :

Surveyor Signature: _____ Surveyor Signature: _____

Page **8** of **8**

HSS-ET-03 -All Level Ambulances (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french **RTSS**=Radio Telephone Switch Station **AED**=Automated External Defibrillator **Laryngoscopes** - reusable or disposable

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
SPRINT REPORT
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number														
UNIT #s→															
1. TWO-WAY RADIO/DAY TO DAY COMMUNICATION:															
FCC type accepted two-way radio communication system for day to day communications;															
2. TWO-WAY RADIO/DISASTER COMMUNICATION CAPABILITY:															
Two-way radio with disaster communications capability- VHF – broadband frequency designated by FCC to be V-MED 28 or HEAR system 155.340 Mhz; with carrier squelch															
2a. Ability to communicate with physician & hospital via HEAR; wireless telephone; RTSS; or Med. 10 System, etc...;															
3. EMR VEHICLES must be EQUIPPED WITH at least the following:															
3a. One fire extinguisher, 10 B:C (secured and identified); *(may be dry chemical ABC or CO^2; no halon)*															
3b. one set of three triangle reflectors (or cyalume light sticks or traffic cones);															
3c. one flashlight, two "C" minimum;															
3d. one current USDOT Hazardous Materials Guidebook;															
3e. per each crew member, one hard hat & safety goggles (ANZI spec) or fire fighter's helmet with face shield; and															
3f. per each crew member, one pair of leather or nomex gauntlet gloves;															
4. BASIC LIFE SUPPORT MEDICAL SUPPLIES as follows:															
4a. one portable suction unit;															
4b. one suction tubing, wide bore (if required);															
4c. one rigid pharyngeal/tonsillar wide bore suction;															
4d. one suction catheter – 5 fr. or 6 fr. or 5/6 fr.;															

Page **1** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
SPRINT REPORT
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number													
UNIT #s→														
4e. one suction catheter, 14 fr. or larger;														
4f. one portable oxygen cylinder, D, Jumbo D, or E, appropriate color;														
4f-i. Maximum of 2000 to 2200 psi, minimum of 500 psi.;														
4g. one variable flow regulator for portable oxygen cylinder with wrench;														
4h. one oxygen nonrebreather mask with tubing, adult;														
4i. one oxygen nonrebreather mask with tubing, pediatric;														
4j. one oxygen nasal prongs with tubing;														
4k. one bag valve mask, adult;														
4l. one bag valve mask, pediatric with infant mask;														
4m. one oral airway, adult;														
4n. one oral airway, child;														
4o. one oral airway, infant;														
4p. one extremity splint device, long;														
4q. one extremity splint device, short;														
4r. one long spine immobilization device with at least 3 points of confinement; 4r-i. a clamshell device may be used;														
4s. one cervical immobilization device;														
4t. one extrication-type cervical collar, pediatric, small; *(adjustable pediatric collar may be used)*														
4u. one extrication-type cervical collar, pediatric, medium; *(adjustable pediatric collar may be used)*														
4v. one extrication-type cervical collar, pediatric, large; *(adjustable pediatric collar may be used)*														
4w. one extrication-type cervical collar, adult, small; *(adjustable adult collar may be used)*														
4x. one extrication-type cervical collar, adult, medium; *(adjustable adult collar may be used)*														
4y. one extrication-type cervical collar, adult, large; *(adjustable adult collar may be used)*														
4z. one burn sheet, sterile;														

Page **2** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

SPRINT REPORT

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: _____/_____/_____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number													
UNIT #s→														
4aa. Ten small sterile dressings 4" x 4", at least 2 per packet;														
4bb. Four large sterile dressings at least 5" x 9";														
4cc. one multi-trauma dressing (at least 10" x30") or 18" x 24" military ABD dressing;														
4dd. Two triangular bandages, manufactured														
4ee. Four complete rolls of roller bandage, soft gauze, at least 2 inches wide;														
4ff. one roll each of Hypoallergenic medical adhesive tape, 1" and 2";														
4gg. Two occlusive dressings, 3" x 8" or larger or commercial chest seal;														
4hh. One liter normal saline for irrigation in plastic container;														
4jj. One tube of oral glucose gel or paste, 12.5 grams, cake icing will suffice;														
4kk. One epinephrine auto-injector, adult, 0.30 mg;														
4ll. One epinephrine auto-injector, pediatric, 0.15mg;														
4mm. One 5 grain (325 mg) aspirin tablet or four 81 grain pediatric aspirin tablets;														
4nn. One Albuterol, 2.5 mg with appropriate delivery device;														
4rr. One disposable OB kit;														
4ss. One roll of aluminum foil or a silver swaddler;														
4tt. One stethoscope;														
4uu. One blood pressure cuff, adult;														
4vv. One blood pressure cuff, pediatric;														
4ww. One pair EMT shears, either issued to Vehicle or individual;														
4xx. One blanket;														
4yy. Twenty-five triage tags;														
4zz. One sharps container, 1 quart; and														
4aaa.One Supraglottic airway, approved by the Louisiana EMS Certification Commission.														

Page **3** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
SPRINT REPORT
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number														
UNIT #s→															
5. AUTOMATED EXTERNAL DEFIBRILLATOR															
All EMR vehicles that are not staffed & equipped to the EMT-paramedic level must carry an AED (automatic or semi-automatic) with the appropriate lead cables and at least two sets of the appropriate disposable electrodes. If AED is capable of manual defibrillation, then an appropriate lock out mechanism (such as an access code, computer chip, or lock and key) to prevent unauthorized use of the device by those persons not authorized to manually defibrillate must be an integral part of the device.															
6. INFECTION CONTROL EQUIPMENT															
6a. one box of gloves, non sterile exam;															
6b. one box of gloves, non latex;															
6c. one pair per crew member, full peripheral glasses with surgical face mask or fluid shields															
6d. one per crew member, N-95 mask;															
6e. one per crew member, disposable, impervious coveralls, gown, jumpsuit;															
6f. one pair per crew member, disposable impervious shoe covers;															
6g. one bottle or 12 towelettes, commercial, antimicrobial hand cleaner;															
6h. one readily identifiable bio hazard disposal bag;															
6i. one per crew member, chemical resistant, full coverage, hooded coverall;															
6j. one pair per crew member, chemical resistant footwear;															
6k. one roll of chemical resistant sealant tape (not duct tape);															
6l. one pair per crew member, chemical resistant goggles with a minimum of N-95 mask;															
6m. one per crew member, incident command vest with florescent trim and appropriate logos;															

Page **4** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
SPRINT REPORT
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number
UNIT #s→	
6n. three per crew member Mark I kits (.7 mg atropine and 2 PAM-V) or one Duodote kit per crew member, per vehicle.	
7. The following must be carried by INTERMEDIATE LEVEL and PARAMEDIC LEVEL EMR vehicles:	
7a. two bags of IV fluid for KVO lines, D5W or isotonic 0.9% NaCl in at least 250 cc bags;	
7a-i. all IV fluids must be in plastic bags or jugs, not glass bottles, unless medically indicated otherwise;	
7b. 1000 cc of Lactated ringers or isotonic 0.9% NaCl in at least 2 approved containers;	
7c. one macrodrip IV administration set;	
7d. two minidrip IV administration sets;	
7e. one three way stopcock extension tubing;	
7f. one each, over-the needle IV catheters, 1.5" long, 14, 16, 18, 20, and 22 gauge;	
7g. one intraosseous needle of choice;	
7h. one venous tourniquet;	
7i. one 1 cc syringe with 0.1 cc graduations;	
7j. one 3 to 6 cc syringe;	
7k. one 30 cc or larger syringe with leur lock;	
7l. one 21 to 23 gauge hypodermic needle;	
7m. one 24 to 26 gauge hypodermic needle; and	
7n. six antiseptic prep pads.	
8. The following must be carried by all PARAMEDIC LEVEL EMR vehicles:	
8a. one pair of Magill forceps, adult;	
8b. one pair of Magill forceps, pediatric;	
8c. one tube or five packets of water soluble lubricating jelly (non cellulose);	
8d. one endotracheal tube, uncuffed (3.0 to 3.5);	
8e. one endotracheal tube, uncuffed, 4.0 to 4.5;	
8f. one endotracheal tube, uncuffed, 5.0 to 5.5;	
8g. one endotracheal tube, cuffed, 6.0 to 6.5;	

Page **5** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY
SPRINT REPORT
Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number													
UNIT #s→														
8h. one endotracheal tube, cuffed, 7.0 to 7.5;														
8i. one endotracheal tube, cuffed, 8.0 to 8.5;														
8j. one stylette, adult;														
8k. one stylette, pediatric;														
8l. one laryngoscope handle with batteries and bulb;														
8m. one set of spare batteries and bulb;														
8n. one laryngoscope blade, straight, size 0														
8o. one laryngoscope blade, straight, size 1														
8p. one laryngoscope blade, straight, size 2;														
8_. One laryngoscope blade, straight or curved, size 3;														
8q. one laryngoscope blade, straight or curved, size 4;														
8r. one monitor defibrillator with electrodes, lead cables, defib pads or jel;														
8s. One glucometer, CLIA approved;														
8t. one pediatric dosing chart;														
8u. one end title CO^2 detection or monitoring device;														
8v. **ANALGESICS:**														
8v-i. one aspirin 5 grain or four 81 mg; and														
8v-ii. morphine*, 10mg/ml;														
8w. **ANTI-ARRHYTHMICS:**														
8w-i. three Adenosine, 6 mg;														
8w-ii. four Atropine, pf, 1 mg;														
8w-iii. one Calcium Chloride, 10 percent, 1 gram;														
8w-iv. three Amiodorone (pre-filled), 150 mg or four Lidocaine, 100 mg pf bolus; and														
8w-v. one Lidocaine, 1 gram; may be premixed														
8x. **ANTI-CONVULSIVE:**														
8x-i. one Valium *, 10 mg/2ml; and														
8x-ii. one Mag Sulfate, 2 grams;														

Page **6** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

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MEDICAL RESPONSE
EMERGENCY VEHICLE SURVEY

SPRINT REPORT

Minimum Equipment & Supply Needs

Provider Name: _____ Inspection Date: ____/____/____
Surveyor Initials: ____ ____

§6055 B. Equipment and Supplies	BLS/ILS/ALS & Unit Number														
UNIT #s→															
8y. **ANTI-HISTAMINE:**															
8y-i. Benadryl, 50 mg;															
8z. **BRONCHODILATORS:**															
8z-i. one Albuterol, 2.5 mg *, inhalation;															
8aa. **CARDIO-VASCULAR:**															
8aa-i. one Dopamine, pm, 200 mg; and															
8aa-ii. three NTG, 0.4 mg Tablet or spray;															
8bb. **DIABETIC CONTROL:**															
8bb-i. one D50W, 50 cc; and															
8bb-ii. one Glucagon, 1 mg;															
8cc. **LOOP DIURECTIC:**															
8cc-i. one Bumex 2 mg; or															
9cc-ii. Lasix; 80 mg;															
8dd. **NARCOTIC ANTAGONIST:**															
8dd-i. one Naloxone, 2 mg;															
8ee. **VASOPRESSORS, 4 mg total:**															
8ee-i. two Epinephrine, 1 mg 1:1000;															
8ee-ii. two Epinephrine, 1 mg 1:10,000; and															
8ee-iii. Vasopressin (optional), 1 mg															

SURVEYOR NOTES :

Surveyor Signature: _____ Surveyor Signature: _____

Page **7** of **7**

HSS-ET-04 -All Level Sprint Vehicles (revised June 11, 2009)

NOTE: **HEAR** = Hospital Emergency Activation Radio **EMR** = Emergency Medical Response **pf**=prefilled **fr** = french
RTSS=Radio Telephone Switch Station **AED**=Automated External Defibrillator **Laryngoscopes** - reusable or disposable
*= or alternative medication approved by appropriate parish/component medical society **pm** = pre-mixed