90-DAY
INVALID SERVICE REVIEW

Date: ______________________________

Service Name: ____File # ___________

Regional Consultant: __________________________ Region: _______________________

Agency Personnel Present: ____

TO BE VERIFIED IN REVIEW:

☐ Personnel Compliance
Rule 1200-12-01-.15 (1) (a)

☐ Dispatch and Run Records
Rule 1200-12-01-.09 (6) (b)

☐ Classification
Rules 1200-12-01-.09 (2)
Classification of Service is Invalid

☐ Deficiencies
List **all** Deficiencies Sited:

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Review findings were presented to the Ambulance Service Director on _____________________
Date

Plan of correction due by: ____________________________
Date

Corrections received and completed: _____________________
Date

☐ **Acceptable**

☐ **Deficient**

DIVISION OF HEALTH LICENSURE AND REGULATION • **OFFICE OF EMERGENCY MEDICAL SERVICES**
665 MAINSTREAM DRIVE • NASHVILLE, TN 37243
TEL: (615) 741-2584 • FAX: (615) 741-4217 • WEBSITE: tn.gov/health/ems

ALL REQUIREMENTS FOR ANNUAL AUDIT HAVE BEEN OUTLINED AND DISCUSSED WITH THE SERVICE DIRECTOR OR DESIGNEE BY THE REGIONAL CONSULTANT DURING THIS NINETY (90) DAY AUDIT REVIEW.

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Agency Representative or Director Signature

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Regional Consultant's Signature