STATE OF FLORIDA
DEPARTMENT OF HEALTH • EMERGENCY MEDICAL SERVICES
Supplemental Inspection Form (SECTION 401.31, F.S.)

Service Name_____ Inspection Date_____/_____/_____ Phone ( )_____

County_____ Type of inspection: ☐ Initial ☐ Reinspection ☐ Random

Type of Service: ☐ BLS ☐ ALS ☐ AIR Unit #_____

Page _____ of _____

Comments (Use additional sheet if necessary)

I, the undersigned representative of the above service, acknowledge receipt of a copy of this inspection form, applicable supplemental forms and corrective action statement (if applicable). In addition, I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies within the established time frames will subject the service and its authorized representatives to administrative action and penalities as outlined in Chapters 401, F.S. and 64E-2, F.A.C. Copy of Inspection and Corrective Action Statement Received by (Person in Charge)_____ Date_____

Inspected by_____ Date_____