



CHECKLIST OF EMERGENCY EQUIPMENT FOR BLS NON-TRANSPORT

State Form 53299 (6-07)

INDIANA DEPARTMENT OF HOMELAND SECURITY

PROVIDER INFORMATION			
Name of provider		Provider certification number	
RESPIRATORY / RESUSCITATION			
Portable suction apparatus - rigid & soft tips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen delivery devices: high concentration	<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	Oxygen delivery devices: low concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pocket mask with one-way valve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oropharyngeal airway, two (2) each: adult, child, infant	<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
Nasopharyngeal airway, two (2) each: small, medium, large	<input type="checkbox"/> Yes <input type="checkbox"/> No		
WOUND CARE SUPPLIES			
Sterile gauze pads, 3" x 3" or larger, ten (10)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bandage shears, one (1) pair	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bandages, soft roller, self-adhering, 2, min. 2" x 4 yards	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adhesive tape, two (2) rolls	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEFIBRILLATION SUPPLIES			
Monitor defibrillator <input type="checkbox"/> Manual <input type="checkbox"/> Semi-automatic <input type="checkbox"/> Automatic	Make	Model	
Defibrillator pads, two (2) sets: adult	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MISCELLANEOUS ITEMS			
Water soluble lubricant for airway insertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnostic penlight or portable flashlight, one (1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stethoscope, one (1) adult	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disposable gloves, two (2) pairs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood pressure manometer, one (1) adult	<input type="checkbox"/> Yes <input type="checkbox"/> No	Basic life support protocols on board	<input type="checkbox"/> Yes <input type="checkbox"/> No
INSPECTION STATUS			
Send written verification to District Manager within ten (10) days of this inspection _____			
COMMENTS			
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Signature of provider representative		Title	Date (month, day, year)
Signature of EMS Commission representative		Date (month, day, year)	