



OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

MOBILE INTENSIVE CARE UNIT INSPECTION

Violation of a bolded field results in automatic reinspection.

SERVICE NAME	SERVICE CODE (6 DIGITS)
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REASON FOR INSPECTION

<input type="checkbox"/> NEW SERVICE	<input type="checkbox"/> RENEWAL	<input type="checkbox"/> NEW VEHICLE
<input type="checkbox"/> REINSPECTION	<input type="checkbox"/> UNANNOUNCED	<input type="checkbox"/> TEMP. PERMIT NUMBER

DESCRIPTION OF VEHICLE

VEHICLE DECAL NUMBER	SERVICE VEHICLE NUMBER	ODOMETER	VEHICLE IDENTIFICATION NUMBER (VIN)
YEAR	MAKE	MODEL	
LICENSE PLATE NUMBER	<input type="checkbox"/> EMS	<input type="checkbox"/> TEMP	<input type="checkbox"/> OHIO <input type="checkbox"/> OUT OF STATE _____

LEVEL OF SERVICE WHEN INSPECTED

<input type="checkbox"/> MoICU	<input type="checkbox"/> Neo-Natal MoICU	<input type="checkbox"/> MoICU / ALS
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INSPECTION DATA

INSPECTOR NAME	DATE OF INSPECTION
Was a violation notification issued for this vehicle?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Is the copy of the violation notification attached to this form?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Is a re-inspection required?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

VEHICLE SAFETY INSPECTION

A. LIGHTING

.01 High and low beam headlights operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Clearance, marker lights, and reflectors operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 High beam indicator light (on dashboard) operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Dashboard lights and interior lights operational (Only if entire system is out)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Left and right tail lights operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Left and right front turn signals operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Left and right rear turn signals operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 ALL brake lights operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 License plate light operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 Back-up lights operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Emergency lighting operational (Only if entire system is out)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

B. TIRES / WHEEL / BRAKES

.01 Tread depth 1/16 inch minimum on all tires	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Tread and sidewall free of major deformities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Rims / wheels free of significant damage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Brake pedal for power brakes operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Emergency / parking brake operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

C. STEERING / SUSPENSION

.01 Steering shaft secure; no excessive play	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Power steering operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Tires have full range of motion without rubbing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Shocks / springs mounted and intact	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Air ride suspension properly inflates / deflates	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

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D. WINDSHIELD / WINDOWS / MIRRORS

.01 Windshield without breach, unobstructed	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Windshield wipers and washers operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Windows without breach and consistent with OEM	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Rear view mirrors without breach	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

E. WARNING DEVICES

.01 Horn operational and audible	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Audible back up alarms operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Siren operable and audible	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

F. MISCELLANEOUS

.01 Driver and passenger safety belts operational	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Driver and passenger safety belts free of visible damage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Seats securely fastened to floor	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Floor intact and free of holes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Interior free of protrusions , trash, and debris	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Structural integrity without breach (body and frame)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Heater, defroster, and A/C installed and operational (front and back)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Exhaust system secured and without breach (visual inspection)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 Fuel tank free of leaks and securely mounted (visual inspection)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 License plates front and rear	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Two-way communications with dispatch and medical control	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Service name / logo permanently on vehicle	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.13 Conformance placard, sticker, or affidavit	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

MoICU EQUIPMENT CHECKLIST

Disposable equipment is acceptable where applicable; equipment / supplies shall not be expired.

G. ISOLATION EQUIPMENT

.01 Kits (4) OR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Isolation goggles and mask or mask / shield combo (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Isolation gowns (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Isolation gloves (4 pairs)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 High particulate filter mask (HEPA or N95) (4 assorted sizes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Containers (bags) for infectious medical waste (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Sharps container	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Disinfectant / germicidal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 Waterless hand cleaner	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

H. AIRWAY EQUIPMENT

.01 Oropharyngeal airway devices infant through adult ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Nasopharyngeal airway devices infant through adult ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Extra batteries and bulbs (If applicable)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Syringes (assorted sizes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Adult stylet	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Pediatric stylet	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Infant Stylet	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Adult Magill Forceps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 Pediatric Magill forceps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 Adult endotracheal tubes (one each cuffed) 6.0mm, 7.0mm, 8.0mm	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Pediatric endotracheal tubes (1 each cuffed or uncuffed 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Water soluble lubricant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

(¹) per medical protocol

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H. AIRWAY EQUIPMENT (continued)

.13 Laryngoscope handle	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.14 Laryngoscope blades (curved and straight) 1, 2, 3, and 4	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.15 End-tidal CO2 detector or capnometer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.16 Cricothyrothomy kit / set ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.17 Ventilator Circuits (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.18 Supraglottic airway devices, adult and pediatric	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.19 Commercial ET tube securing device	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

I. ONBOARD DEFINITIVE CARE EQUIPMENT

.01 Approved medications as shown on Ohio State Board of Pharmacy License / Addendum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 ECG monitor / defibrillator (with EKG trace) external cardiac pacing capability²	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Adult and Pediatric paddles / pads (1 set)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 ECG leads	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 External pacemaker and pads	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Hemodynamic invasive monitoring equipment (monitor cable and transducer set)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Pulse oximeter	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Doppler and gel	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 IV Pumps (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 Ventilator with minimum of PEEP	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Generator and 110 power source (permanently mounted and wired in the vehicle)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Chest tube drainage system	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

J. BLEEDING CONTROL / BURN EQUIPMENT

.01 Adhesive dressing strips (10)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Sterile gauze pads (20)(assorted sizes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Surgi pads / sterile sponge pads (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Assorted standard gauze rolls (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Sterile universal trauma dressing 10" X 36" (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Sterile water and / or 0.9% saline for irrigation (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

K. SUCTION EQUIPMENT

.01 Permanently installed suction unit	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Portable suction unit (powered or hand operated)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Rigid pharyngeal curved suction catheters wide-bore tubing (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Soft tip suction catheter (2 sizes) 1 between 6.0 and 10 French and 1 between 12 and 16 French	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Sterile water and / or NS (4) minimum 1000ml excluding IV solutions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Sterile gloves (2 pairs)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Suction tubing (2)			
.08 Suction bags (2 extra disposable liners or containers)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

L. MEDICAL GAS AND EQUIPMENT

.01 Main oxygen (M tank or greater) (current hydrostatic testing)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Wall mounted oxygen gauge (0-15 LPM minimum)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Portable oxygen unit (2) secured in appropriate tank storage mechanism (minimum "D" tanks) (current hydrostatic testing)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 One portable variable flow regulator (0-15 LPM minimum)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Bag-valve-mask with reservoir 100% oxygen flow:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Adult (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Pediatric (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

(1) per medical protocol

(2) Battery tested and has up-to-date service record

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L. MEDICAL GAS AND EQUIPMENT (continued)

.08 Infant (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 Transparent masks simple and non-rebreather:			
.10 Adult (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Pediatric (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Infant (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.13 Nasal cannulas:			
.14 Adult (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.15 Pediatric	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.16 Infant (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.17 Oxygen connective tubing and appropriate adapters	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.18 Nebulizers and appropriate connecting tubing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.19 Gas shut-off access from patient care compartment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

M. ADJUNCT EQUIPMENT

.01 Trauma Shears (1)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Stethoscope (1)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 BP Cuffs:			
.04 Infant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Pediatric	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Adult	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Large Adult	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Thermometer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 Penlight	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 Flashlight	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.11 Patient cot with 3 straps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Isolette with 2 straps ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.13 Eye shields or protector pads (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.14 Assorted tape (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.15 Exam gloves (1 box small, medium, and large or 1 box uni-size)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.16 Emesis basins or equivalent (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.17 Obstetrical kit	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.18 Urinal or equivalent	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.19 Bedpan (1)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.20 Personal towelettes or equivalent (10)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.21 ABC fire extinguishers minimum classification 2-A:10-B:C compliant (2) (front and back)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.22 Extinguishers meet mounting requirements of national standard	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.23 Extinguishers meet OSHA requirement for annual testing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.24 Nasogastric tubes adult and pediatric	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.25 Patient restraints (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.26 Hot and cold packs (2 each)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.27 Pillows and cases (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.28 Sheets (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.29 Heavy Blankets (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.30 Towels (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.31 Water soluble lubricant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.32 ANSI II high visibility vest for each crew member	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.33 Age / weight appropriate pediatric restraint ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

(¹) per medical protocol

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N. INTRAVENOUS EQUIPMENT

.01 Disinfecting preps (10 each)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Short arm boards (2 each)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 IV administration sets (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 IV infusion pump tubing (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 IV catheters (assorted sizes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Intraosseous needles (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Three-way stopcocks (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.08 Needles (assorted sizes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.09 IV solutions (2) ¹	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.10 Associated adjunct equipment:			
.11 Invasive line set-up (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.12 Pressure bags (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

O. NEONATAL SPECIFIC MOICU

.01 Infant head hoods (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Infant transport isolette readily available	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Infant laryngoscope straight blade size 00	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Neonatal blood pressure cuffs, size 1, 2, 3, 4	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Neonatal nasogastric tubes, assorted sizes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Neonatal chest tubes, assorted sizes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

P. IMMOBILIZATION EQUIPMENT (COMBO UNIT)

.01 Extremity immobilization devices (board, air, vacuum, ladder, or equivalent)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.02 Traction splint (Adult Only)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.03 Backboard or equivalent (2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.04 Backboard straps (3 each per board)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.05 Commercial cervical immobilization device (2) Adult	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.06 Rigid extrication collar (Infant-Child-Adult) (small-medium-large)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
.07 Stairchair and / or combo stairchair / folding cot (1)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A

The MoICU inspection form contains the vehicle roadworthiness requirements and equipment required for a permitted MoICU authorized by section 4766 of the Ohio Revised Code and Ohio Administrative Code and as approved by the State Board of Emergency Medical, Fire, and Transportation Services.

COMMENTS

(¹) per medical protocol