STATE OF FLORIDA
DEPARTMENT OF HEALTH · EMERGENCY MEDICAL SERVICES
Inspection Narrative (Section 401.31, F.S.)

Service Name: _____ Date: ____/____/_____ Phone: (___) _____

County: _____ Type of Inspection: ☐Initial ☐ Reinspection ☐ Random

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

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Comments (Use additional sheet if necessary)

I, the undersigned representative of the above service, acknowledge receipt of a copy of this inspection narrative, applicable supplemental inspection reports 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 penalties as outlined in Section 401, F.S., and Chapter 64J-1, F.A.C. Copy of Inspection report and Corrective Action Statement Received by:

Person in Charge: _____ Date: _____/_____/_____

Inspected by: _____ Date: _____/_____/_____