



**Massachusetts Department of Public Health
Office of Emergency Medical Services
Ambulance Regulation Program
PLAN OF CORRECTION**



Service Number

--	--	--	--

License Expiration Date

--	--	--	--	--	--	--	--

Insp.

--

RESPONSE DUE BY:

--

Service Name

--

VEHICLE INFORMATION (if Applicable)

Is this vehicle a(n) ___ Addition ___ Replacement ___ Renewal

License Plate Number _____ Ambulance Class _____ Vehicle Unit Id _____

Vehicle Identification Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Page	Citation	Providers Plan of Correction (provide details of corrective action that satisfies reported deficiencies) (for page and citation number refer to inspection report form)	Completion Date
Licensee representative's signature		Title	Date

Send P.O.C. to: Dept of Public Health - O.E.M.S Ambulance Regulation Program

Note: Services using online form, keep one copy for your records and send one copy to OEMS