<table>
<thead>
<tr>
<th>Service Number</th>
<th>License Expiration Date</th>
<th>Insp.</th>
<th>RESPONSE DUE BY:</th>
</tr>
</thead>
</table>

**Service Name**

### VEHICLE INFORMATION (if Applicable)

- **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)

<table>
<thead>
<tr>
<th>Page</th>
<th>Citation</th>
<th>Providers Plan of Correction</th>
</tr>
</thead>
</table>

**Completion Date**

Licensee representative’s signature

**Title**

**Date**

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

99 Chauncy St., 11th Floor, Boston, MA 02111

Tel: 617-753-7300, Fax: 617-753-7320

OEMS Form 500-63 (8/09)

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