



# New Jersey EMS Task Force

Staff Use: Demob	___
D4H Initial	___ Final ___

## Emergency Medical Services

### Vehicle Check-in and Personnel Accountability Record

Please complete and return this form to the EMS Staging Area

#### Vehicle Type:

- BLS Ambulance     ALS Transport     ALS Non-Transport     SCTU Ambulance  
 ASAP     MAB     MCRU     SAMT     SOV     Prime Mover  
 Other: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Vehicle ID: \_\_\_\_\_ Agency State: \_\_\_\_\_ County: \_\_\_\_\_

Total # of Personnel: \_\_\_\_\_ License Plate State: \_\_\_\_\_ Plate #: \_\_\_\_\_

Fuel Type: Gasoline Diesel Fuel Level: F 3/4 1/2 1/4

First & Last Name / Cell #	Certification Level	Email
	Emergency Contact Name	Emergency Contact #
First & Last Name / Cell #	Certification Level	Email
	Emergency Contact Name	Emergency Contact #
First & Last Name / Cell #	Certification Level	Email
	Emergency Contact Name	Emergency Contact #
First & Last Name / Cell #	Certification Level	Email
	Emergency Contact Name	Emergency Contact #

Do all personnel have a **HELMET**? **Y N** Do all personnel have **RESPIRATORY PROTECTION**? **Y N**

Type of respirators available: **N95 APR SCBA** Are personnel **FIT-TESTED** for the respirators? **Y N**

Agency Contact Name & Phone #: \_\_\_\_\_

Agency Dispatch Name & Phone #: \_\_\_\_\_

**While in the EMS Staging Area, please remain in your vehicle until you receive a status. Do not remove your stretcher or equipment from your unit unless directed to do so.**