

SACRED MOUNTAIN MEDICAL SERVICE  
Vehicle/Equipment Repair Work Order

DATE NOTED: \_\_\_\_\_ PERSON REPORTING: \_\_\_\_\_

ITEM NEEDING REPAIR: \_\_\_\_\_ UNIT # \_\_\_\_\_

EQUIPMENT S/N: \_\_\_\_\_ MILEAGE: \_\_\_\_\_

LOCATION OF VEHICLE/EQUIPMENT: \_\_\_\_\_ TAKEN OUT OF SERVICE?: Y N

DESCRIPTION OF PROBLEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ACTION(S) TAKEN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If the failure/malfunction occurred on a call:

CALL DATE: \_\_\_\_\_ INCIDENT NUMBER: \_\_\_\_\_

Upon completion immediately fax to the SMMS dispatcher at (928) 283-8296

.....  
(Administration Use Below This Line)

RECEIVED BY: \_\_\_\_\_ DATE/TIME: \_\_\_\_\_

ADDITIONAL COMMENTS RECEIVED BY REPORTING PERSON?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ACTION(S) TAKEN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OUTCOME OF REPAIR: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PERSON TAKING IN REPORT AT INVOICE PAYMENT

NAME: \_\_\_\_\_ DATE/TIME: \_\_\_\_\_