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: _____