Texas Department of State Health Services

MAIL , FAX, OR E-MAIL COMPLETED FORM TO:

MC 1987
TEXAS DEPT OF STATE HEALTH SERVICES
ATTN: EMS PSQA UNIT
P.O. BOX 149347
AUSTIN, TEXAS 78714-9347
FAX: 512/821-4510
E-Mail: EMS_Complaint@dshs.state.tx.us

(DO NOT FILL IN, State office use only)

Date complaint form received:

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Complaint Tracking #:

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COMPLAINT FORM
EMERGENCY MEDICAL SERVICES

Name of person making complaint: ______________________________

Mailing address of person making complaint: ______________________________

City, State, Zip of person making complaint: ______________________________

Phone number of person making complaint: ______________________________

Your Relationship to subject of compliant (Patient being treated, Family of Patient, Coworker, Employee, Employer, Receiving Facility, Bystander): ______________________________

Licensee Name (Alleged Violator):

____

License Type: (EMT, Paramedic, EMS Provider, First Responder Organization, Coordinator, Instructor): ______________________________

Physical address (if known): ______________________________

City, State, Zip (if known): ______________________________

Phone Numbers (if known): ______________________________

Date of incident: ______________________________

Patient Name (if applicable): ______________________________

Your Relationship to the patient (if applicable): ______________________________

Names of Witness #1: ______________________________

Witness #1Address: ______________________________

Witness #1 Phone Numbers: ______________________________

Names of Witness #2: ______________________________

Witness #2 Address: ______________________________

Witness #2 Phone Numbers: ______________________________

(Continued on next Page)

Questions to be addressed in the narrative:

1. What happened, who was involved (i.e. staff, family, visitors, other patient(s), by-standers, etc)?
2. Is your name releasable or do you wish to remain anonymous (if anonymous, no follow up or results will be given to complainant)?
3. Are there any witnesses to the incident? (If so, List names, addresses and phone numbers.)
4. Did you report your concerns to the EMS ambulance provider or its EMS staff? (If so, List names, addresses.)
5. Are law enforcement agencies involved? (If so, List names and office locations and names of agents spoken to.)
6. Are any other state agencies involved? (If so, List names and office locations and phone numbers of agents spoken to.)
7. Did the Emergency Medical Provider try to help you resolve the issues? (If so, describe its response.)
8. Do you have knowledge that any similar incidents have happened before? (If so, describe in detail those events, including specific times, dates, locations, names of witnesses, how you become of aware of the incidents, etc.)

Note: This Department does not have regulatory authority over EMS charges or billing disputes.

NARRATIVE

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ATTACH ADDITIONAL SHEETS IF NECESSARY
PLEASE NUMBER ALL PAGES (Example: Page 3 of 3)

Upon receipt, your complaint will be entered into our tracking system and given a number. Unless this complaint was filed anonymously, you will be sent a letter informing you of this number as well as a contact person's name and phone number should you wish to inquire as to the status of your complaint.

Rev:20090720

(End of Form)