



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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

MC 2822
TEXAS DEPT OF STATE HEALTH SERVICES
ATTN: EMS COMPLIANCE GROUP
P.O. Box 149347
AUSTIN, TEXAS 78714-9347
FAX: 512/821-4510 or 512/834-6713
E-Mail: EMS_Complaint@dshs.state.tx.us

(DO NOT FILL IN, State office use only)

Date complaint form received:

Complaint Tracking #:

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 complaint (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 #1 Address: _____

Witness #1 Phone Numbers: _____

Names of Witness #2: _____

Witness #2 Address: _____

Witness #2 Phone Numbers: _____

Questions to be addressed in the narrative:

1. What happened, who was involved (i.e. staff, family, visitors, other patient(s), bystanders, 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 aware of the incidents, etc.)

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

NARRATIVE

(Continued on next Page)

