

EMERGENCY MEDICAL SERVICES COMPLAINT FORM

This form may be used to file complaints about acts or practices relative to Emergency Medical Services. Please provide as much of the requested information as you are able.

REPORTER/COMPLAINANT CONTACT INFORMATION

Name of Complainant: _____

Address: _____

Mailing Address: _____

Telephone: _____ Email Address: _____

Name of Person Filing this Report (if different from above): _____

Date Complaint Filed: _____

NOTE: If you are filing this report on behalf of an Ambulance Service or Organization, please identify said

Organization: _____

If you are an ambulance service, and this issue meets the definition of "serious incident" as defined in 105 CMR 170.350(B), please complete the "EMS Serious Incident Form," available at the OEMS website, at www.mass.gov/dph/oems/forms.

SUBJECT(s) OF COMPLAINT

(Complete, to the best of your ability, those areas that apply.)

Emergency Medical Technician(s):

NAME

CERTIFICATION NUMBER

Ambulance Service:

NAME

LOCATION

Training Institution:

NAME

LOCATION
