

LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
Emergency Medical Services Commission

COMPLAINT / REPORTING FORM

Submit to:
EMS Certification Commission
7273 Florida Blvd.
Baton Rouge, La., 70806
Phone: (225) 925-4022
Fax: (225) 925-7244
Email: EMS.commission@la.gov

The EMS Certification Commission reviews complaints that an individual has engaged in, or is engaging in, any conduct proscribed by R.S. 40:1133.7, and the complaint may be made by any person, staff, agency, or the commission. Such complaints shall be made on this form, and shall have attached copies of all evidence to support the allegations. If your complaint appears to show the existence of a violation of the statutes or rules related to emergency medical services in Louisiana, an investigator may contact you for further information. Depending on the nature of the allegations, the complaint may be referred to another Department, Office, or state regulatory agency or board.

COMPLAINANT INFORMATION

Your Name/Company Contact Number

Address

Would you be willing to testify if this matter goes to a formal administrative hearing? Yes No

SUBJECT OF COMPLAINT

Complaint is filed against National Registry Number

Subject Name Contact Number

Address

Nature of Complaint (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Quality of Care | <input type="checkbox"/> Alcohol / drug abuse |
| <input type="checkbox"/> Practicing without certification / with expired certification | <input type="checkbox"/> Violation of patient confidentiality |
| <input type="checkbox"/> Criminal Arrest/Conviction | <input type="checkbox"/> Practicing beyond scope of certification |
| <input type="checkbox"/> Sexual abuse / harassment or contact | <input type="checkbox"/> Patient abandonment / neglect / abuse |
| <input type="checkbox"/> Falsifying records | <input type="checkbox"/> Misappropriating items of an individual / agency / entity |
| <input type="checkbox"/> Failure to report | <input type="checkbox"/> Other (Please describe in narrative) |

PATIENT INFORMATION (if applicable)

Patient Name Contact Number

Address

Relationship of Complainant to Patient

I hereby give the Louisiana Emergency Medical Services Commission permission to send a copy of my complaint to the practitioner listed above and that this will include disclosing my identity. I may elect not to sign below and thus request that my identity be kept confidential. In that case, a summary of the complaint may be provided to the practitioner. I understand however, that even if I do not sign below and have the Commission handle this complaint confidentially, that the Commission may be required by law to disclose my identity to the practitioner at a later stage of the proceedings.

Signature Date

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Please describe in detail, in the space below, what occurred to warrant this complaint including: facts, details, locations, dates, times, witness (es) with contact information, etc. Please attach/submit copies of medical records, correspondence, contracts, newspaper articles, disciplinary reports, termination reports, drug screen results, and/or any other documents that will help support your complaint/report.