

LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
Certification 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. Communications from the complainant shall be privileged and shall not be revealed to any person unless such documents will be offered for evidence in a formal hearing, or unless subpoenaed by a court, or requested by other regulatory agencies.

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

By affixing an electronic signature below, I attest that all statements provided on this complaint form and in any supplemental documents submitted to the EMS Certification Commission are true, accurate, and complete to the best of my knowledge and belief.

Signature Date

Louisiana Department of Health
Bureau of Emergency Medical Services
Certification Commission

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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.