OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

COMPLAINT FORM FOR EMS, FIRE, OR MEDICAL TRANSPORTATION

COMPLAINT AGAINST: (EMS Provider, Educational Institution, EMS Instructor; Firefighter, Fire Instructor, Fire Safety Inspector, Non-Emergency, Emergency, or Air Medical Service Organization)

SERVICE OR INSTITUTION NAME			SERVICE OR INSTITUTION ID NUMBER	
STREET ADDRESS OF SERVICE OR INSTITUTION			CITY	
STATE			ZIP CODE	TELEPHONE NO. EXT.
INDIVIDUAL LAST NAME		FIRST NAME		MI
STREET ADDRESS			APT / CITY	
STATE	COUNTY		ZIP CODE	TELEPHONE NO. EXT.
EMS/FIRE CERTIFICATE NUMBER (If known)		LEVEL OF EMS/FIRE CERTIFICATION (If known)		
EMS OR FIRE AGENCY - AFFILIATION				
EMS OR FIRE AGENCY AFFILIATION - STREET ADDRESS			CITY	
STATE	COUNTY		ZIP CODE	TELEPHONE NO. EXT.

NOTICE TO COMPLAINANT:
Pursuant to the Ohio Administrative Code, the Ohio Department of Public Safety, Division of Emergency Medical Services may investigate alleged violations of Chapters 4765 and 4766 of the Ohio Revised Code and the rules promulgated thereunder. Please note that if your complaint is determined not to be a violation of Chapter 4765 or 4766, it may be forwarded to the appropriate agency.

COMPLAINT FILED BY: In accordance with the Ohio Administrative Code, Chapters 4765 and 4766, EMS and Medical Transportation complaints may be filed anonymously. With the exception of complaints related to written or practical examinations, fire complaints may NOT be filed anonymously. **Please note that the Division of EMS cannot provide a response to you regarding disposition of your complaint without contact information.**

LAST NAME		FIRST NAME		MI
STREET ADDRESS			APT / CITY	
STATE	COUNTY		ZIP CODE	TELEPHONE NO. EXT.
LEVEL OF EMS/FIRE CERTIFICATION (If known)			E-MAIL ADDRESS	
EMS AGENCY, FIRE DEPT., INSTITUTION, OR COMPANY (if applicable)			STREET ADDRESS	
CITY	COUNTY		STATE	ZIP CODE

DESCRIPTION OF COMPLAINT: (Describe event, conduct, behavior or circumstances that you believe to be improper. Please provide as much detail as possible, to include, but not limited to date, time, location)

WITNESSES

LAST NAME	FIRST NAME	MI	TELEPHONE NO.	EXT.
ADDRESS	CITY	STATE	ZIP CODE	
LAST NAME	FIRST NAME	MI	TELEPHONE NO.	EXT.
ADDRESS	CITY	STATE	ZIP CODE	
LAST NAME	FIRST NAME	MI	TELEPHONE NO.	EXT.
ADDRESS	CITY	STATE	ZIP CODE	
LAST NAME	FIRST NAME	MI	TELEPHONE NO.	EXT.
ADDRESS	CITY	STATE	ZIP CODE	

WHAT REMEDY ARE YOU SEEKING?

SIGNATURE:

By signing this complaint, I attest that all the information provided is true to the best of my knowledge. I also acknowledge that I am willing to provide a sworn statement concerning this complaint.

SIGNATURE OF INDIVIDUAL MAKING COMPLAINT	DATE
X	

PLEASE MAIL COMPLETED FORM TO:

OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES
1970 WEST BROAD STREET
P.O. BOX 182073
COLUMBUS, OH 43218-2073
PHONE: (800) 233-0785 or (614) 466-9447
FAX: (614) 466-9461