

EMERGENCY MEDICAL SERVICES COMPLAINT

This form is required for those individuals interested in filing a complaint against a licensed emergency medical services personnel, service, or EMS training center. If you believe a violation of Wis. Stat. ch. 256 or Wis. Admin. Code ch. DHS110 has occurred you may complete this form and submit to the Wisconsin EMS Section for investigation and disposition. Return this completed form and necessary attachments via email to dhsemssmail@wisconsin.gov or via USPS to: Complaints & Investigations, WI EMS Section, 1 W Wilson St., P O Box 2659, Madison, WI 53701-2659.

COMPLAINT AGAINST

Last Name	First Name	MI
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Ambulance Service Name / Training Center Name

Mailing Address

City	State	Zip Code	County	Telephone Number
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License Number (If Known)

License Level (If Known)

FILED BY

Last Name	First Name	MI
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Company Name

Mailing Address

City	State	Zip Code	County	Telephone Number
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RELATIONSHIP TO PATIENT

- Self
 Parent
 Son / Daughter
 Legal guardian (Provide court documents)
 Spouse
 Brother / Sister
 Friend
 Other (Please specify)

Please note: If other than patient or parent of minor patient, please provide documentation indicating appointment of legal authority / guardianship.

NATURE OF COMPLAINT (Check all that apply)

- Quality of care
 Insurance fraud
 Sexual abuse, harassment or contact
 Criminal Conviction
 Substance abuse
 Drug diversion
 Run report falsification
 Patient abandonment/neglect
 Unlicensed practice
 Other than listed (Please specify)

Please note: If other than patient or parent of minor patient, please provide documentation indicating appointment of legal authority / guardianship.

Have you attempted to contact the EMS provider concerning your complaint?

Yes No Date

What was their response to your complaint?

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

WITNESS 1

Last Name	First Name	MI
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Mailing Address

City	State	Zip Code	County	Telephone Number
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WITNESS 2

Last Name	First Name	MI
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Mailing Address

City	State	Zip Code	County	Telephone Number
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WITNESS 3

Last Name	First Name	MI
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Mailing Address

City	State	Zip Code	County	Telephone Number
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WITNESS 4

Last Name	First Name	MI
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Mailing Address

City	State	Zip Code	County	Telephone Number
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WITNESS 5

Last Name	First Name	MI
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Mailing Address

City	State	Zip Code	County	Telephone Number
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COMPLAINT

In the space below, please provide the pertinent information regarding the complaint. Provide names, dates, times, places, and as much detail as possible of the event.

What remedy / result are you seeking / expecting? Please describe below:

By Submitting this application you are affirming that all statements you have made in this document are true. You understand that the EMS Section has the right to determine what action will be taken and if a full investigation is warranted.

SIGNATURE - Person filing complaint	Date
Print Name	

SEND FORM VIA E-Mail to:

dhsemssmail@wisconsin.gov

OR

Form May Be Mailed To:

Complaints & Investigations
WI EMS Section
1 W Wilson St
PO Box 2659
Madison, WI, 53701-2659