MAIL, FAX, OR E-MAIL COMPLETED FORM TO:

NEW MEXICO DEPARTMENT OF HEALTH
ATTN: EMS ENFORCEMENT SECTION
EMERGENCY MEDICAL SYSTEMS BUREAU
1301 SILER RD., BUILDING F
SANTA FE, NEW MEXICO 87507
FAX: 505-476-8262

Date complaint form received: ____________________________________________

Complaint Tracking #: ________________________________________________

This form may be used to submit a complaint regarding an Emergency Medical Technician, Emergency Medical Dispatcher, EMS Service (Ground & Air), EMS Training Program, or EMS Instructor. Please submit the completed form to the mailing address or fax number displayed above. If your complaint appears to show a violation of the statutes or rules related to Emergency Medical Systems in New Mexico, an investigator will contact you for further information during the course of the investigation process. Depending on the nature of the complaint, the complaint may be referred to another Department office or to another state regulatory agency or board.

EMERGENCY MEDICAL SYSTEMS COMPLAINT FORM

Name of person making complaint: __________________________________________
Mailing address of person making complaint: _____________________________
City, State, Zip of person making complaint: ______________________________
Phone number(s) of person making complaint: ___________________________
E-mail address of person making this complaint: ___________________________
Your Relationship to the subject of complaint (Patient, Family of Patient, Coworker, Employee, Employer, Receiving Facility, Bystander): ________________________________

Licensee or EMS Service Name (Alleged Violator):

______________________________________________________________
License Type: (Emergency Medical Technician (EMSFR, Basic, Intermediate, Paramedic),
Emergency Medical Dispatcher, EMS Service (Air & Ground), Training Program, Instructor):

______________________________________________________________

Alleged violator's employer (if known): ______________________________________
Alleged violator's physical address (if known): ________________________________
Alleged violator's City, State, Zip (if known): _________________________________
Alleged violator's phone numbers (if known): ________________________________
Date of incident: ________________________________________________________________

Patient Name (if applicable): ______________________________________________________

Patient record number (if known): ________________________________________________

Your Relationship to the patient (if applicable): _____________________________________

Names of Witness #1: ____________________________________________________________

Witness #1 Address: ______________________________________________________________

Witness #1 Phone Numbers: _______________________________________________________

Names of Witness #2: ____________________________________________________________

Witness #2 Address: ______________________________________________________________

Witness #2 Phone Numbers: _______________________________________________________

Questions to be addressed in the narrative:

1. What happened, who was involved (i.e. staff, family, visitors, other patient(s), bystanders, etc)?
2. Are there any witnesses to the incident? (If so, list names, addresses and phone numbers.)
3. Did you report your concerns to the EMS service provider or its EMS staff? (If so, list names, addresses.)
4. Are law enforcement agencies involved? (If so, list names and office locations and names of agents spoken to.)
5. Are any other state agencies involved? (If so, list names and office locations and phone numbers of agents spoken to.)
6. Did the Emergency Medical Provider try to help you resolve the issues? (If so, describe its response.)
7. Do you have knowledge that any similar incidents have happened before? (If so, describe in detail those events, including specific times, dates, locations, names of witnesses, how you became aware of the incidents, etc.)

Note: This Department does not have regulatory authority over EMS charges or billing disputes.

NARRATIVE
By affixing a signature below, I attest that all statements provided on this complaint form and any supplemental documents submitted to the Bureau are true, accurate, and complete to the best of my knowledge and belief.

Complainant Signature ___________________________ Date ___________________________

Information, documents and records received by the Department or prepared by the Department in connection with an investigation relating to an EMT or EMS Service are considered confidential and not subject to public inspection or civil discovery, unless and until the EMS Licensing Commission authorizes the EMS Bureau to initiate an action in the case of personnel licensure. 7.27.2.13(G)(6)(a) NMAC. If the EMS Licensing Commission authorizes that an action be taken by the EMS Bureau, those investigation materials that are not considered exempt under the Inspection of Public Records Act at NMSA § 14-2-1 et seq., or otherwise privileged or confidential under applicable laws, will be made available for public inspection. If the EMS Licensing Commission does not authorize the EMS Bureau to initiate an action, investigation materials will remain confidential and not available for public inspection.

Except as provided above, during the course of an investigation or enforcement action, the name of the complainant is public record unless the Department determines that the release of the complainant's name may result in substantial harm to any person or to the public health or safety.

(End of Form)