Rick Scott
Governor

BUREAU OF EMERGENCY MEDICAL SERVICES
Investigation Section
COMPLAINT FORM

Please Return To: Bureau of Emergency Medical Services
c/o Investigation Section
4052 Bald Cypress Way, Bin C-18
Tallahassee, Florida 32399-1701

The Department of Health Bureau of Emergency Medical Services is responsible for investigating complaints involving service providers, training schools/colleges and 911 Public Safety Telecommunicators.

To file a complaint/report, compete, sign and notarize or witness this form and provides dates and details regarding your complaint.

Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint. The Authorization for Release of Patient Information form included on page 4 must be completed and signed in order to process your complaint, as a health care practitioner cannot even disclose that you are his/her patient without this authorization (if applicable). The Department will acknowledge receipt of your complaint/report by letter. If the allegations contained in your complaint are determined to be possible violations of applicable laws and rules, your complaint will be assigned for investigation.

If you have questions about the complaint process, contact the Bureau of EMS Investigation Section at (850) 245-4440.

ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT/BUREAU OF EMS INCLUDE:

- **Fee or Billing disputes (i.e. the amount a provider charges for services).**
- **Rudeness or personality conflicts (i.e. provider or staff's attitude or professionalism).**

Health care practitioners are regulated by professional boards under the purview of the Department of Health and the action which may be taken by the professional boards is administrative in nature (i.e. reprimand, fine, restriction of practice, remedial education, administrative cost, suspension, or revocation). The Department of Health cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters. The Department of Health is not a law enforcement agency. If you believe this complaint may be a crime, please report it to your local law enforcement agency immediately.

Bureau of Emergency Medical Services
4052 Bald Cypress Way, Bin C18 • Tallahassee, Florida 32399-1701
Phone: (850) 245-4440 • Fax: (850) 921-0377 • http://www.floridashealth.com

Rick Scott
Governor

COMPLAINANT/REPORTER:
Your Name/Company:______________________________
Address:______________________________
(Street) (City) (State) (Zip)
Telephone: (____) ______________________________
(Home) (Work)

SUBJECT OF COMPLAINT/REPORT:
Provider's Name/Training Name: ______________________________
Address: ______________________________
(Street) (City) (State) (Zip)
Telephone: (____) ______________________________
(Home) (Work)
Profession:______________________________**(i.e. ALS, BLS, Air, Training School or 911 PST)**
License #: ______________________________

Name of Patient if other than yourself: ______________________________
Address of Patient if other than yourself: ______________________________
____
(Street) (City) (State) (Zip)
Telephone: (____) ______________________________

Relationship of Complainant to Patient:
( )Self ( ) Patient ( ) Son/Daughter ( ) Legal Guardian (provide documentation)
( ) Spouse ( ) Brother/Sister ( ) Friend ( ) Other Physician ____________________
( ) Other ______________________________

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
( ) Operating without a license
( ) Failure to provide true information
( ) Insurance fraud
( ) Failure to report
( ) Operating beyond scope of license
( ) Misfilled/mislabeled prescription
( ) Failure to release patient records
( ) Patient abandonment/neglect
( ) Employing a non-Florida certified EMT/Paramedic/ 911Public Safety Telecommunicator
( ) Advertising violation
( ) Problem other than listed above ______________________________

Have you attempted to contact the provider concerning your complaint? ( ) YES ( ) NO
Date: ______________________________

Would you be willing to testify if this matter goes to a formal hearing? ( ) YES ( ) NO
If the incident complained of involved criminal conduct, you should contact your local law enforcement authority.

Have you contacted your local law enforcement authority? ( ) YES ( ) NO
If yes, state the name of the person or office that you contacted: ____________________
When did you make this contact? ______________________________
Please give case number if available: ______________________________

Bureau of Emergency Medical Services
4052 Bald Cypress Way, Bin C18 • Tallahassee, Florida 32399-1701
Phone: (850) 245-4440 • Fax: (850) 921-0377 • http://www.floridashealth.com

Please list any prior and/or subsequent treating practitioners relative to your complaint (please give full name, address and telephone number).

Witnesses (Please give full name, address and phone number).

Please give full details of your complaint/report; include facts, details, dates, locations, etc. (attach additional sheets if necessary). Please attach copies of medicals records, correspondence, contracts, and any other documents that will help support your complaint.

What would satisfy your complaint?

Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature (required to file complaint)

Date

Bureau of Emergency Medical Services
4052 Bald Cypress Way, Bin C18 • Tallahassee, Florida 32399-1701
Phone: (850) 245-4440 • Fax: (850) 921-0377 • http://www.floridashealth.com

Rick Scott
Governor

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: Any and all treating health care practitioners or facilities

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA Privacy Law) found at 45 CFR, Part 164.

A photocopy of this document is as sufficient as the original

This document authorizes any and all licensed health care practitioners, including but not limited to: Physicians, nurses, therapists, social workers, counselors, dentist, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants, and other person who have participated in providing any health care service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.

This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use of licensure or disciplinary actions, and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation. This authorization is in effect until related disciplinary proceedings are concluded.
I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

____
Patient Name (Please Print)

______________________________ ______________ ____________________ ______________
Patient Signature D.O.B. Social Security No. Date

____ ______________________
Name of Authorized Person Other than Patient (Please Print) Relationship

____
Signature of Authorized Person Other than Patient

STATE OF ________________ COUNTY OF ____________________
Before me, personally appeared ________________________________
Whose identity is known to me by ______________________________
(type of identification) and who, acknowledges that his/her signature appears above.

Sworn to or affirmed by Affiant before me this _________________day of ___________, 20__

______________________________ ______________________________
NOTARY PUBLIC My Commission Expires

______________________________ ______________________________
Name (Please Print) Witness Signature (if not notarized)

Bureau of Emergency Medical Services
4052 Bald Cypress Way, Bin C18 • Tallahassee, Florida 32399-1701
Phone: (850) 245-4440 • Fax: (850) 921-0377 • http://www.floridashealth.com

Inv. Form Revised 02/11