Arizona Department of Health Services
Bureau of Emergency Medical Services and Trauma System
Complaint Form

The Bureau of Emergency Medical Services & Trauma System (Bureau) prefers that complaints be submitted on this complaint form. This form may be used to submit a complaint regarding an Emergency Medical Care Technician ("EMCT"), Air or Ground Ambulance service, ALS Base Hospital, Training Program, or Trauma Center. *Depending on the nature of the complaint, the complaint may be referred to another Department office or to another State regulatory agency or board.*

If your complaint appears to show the existence of a violation of the statutes or rules related to Emergency Medical Services in Arizona, an investigator will contact you for further information during the course of the investigation process.

Please submit this completed complaint form to the mailing address, e-mail address, or fax number displayed to the right.

Emergency Medical Services & Trauma System
Attn: Investigation Section
150 N. 18th Avenue, Suite 540
Phoenix, Arizona 85007-3248
Fax: (602) 364-3567
E-mail: BEMSTScompliance@azdhs.gov

Information, documents, and records received by the Department or prepared by the Department in connection with an investigation relating to an EMCT are confidential and are not subject to public inspection or civil discovery. The results of the investigation and the decision of the Department shall be made public when the investigation has been completed and the investigation file has been closed. A.R.S. §§ 36-2220(E) and 36-2245(M).

My Contact Information is:

Name:		Telephone:		Cell Phone:	
Mailing Address:			Apartment, Suite, Room		
City:		State:		Zip:	

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. A.R.S. § 41-1010.

This Incident Occurred on the following Date, Time and Location:

Date of the Incident:		Time of the incident:		Location of the Incident:	

The Following Patient is Related to My Complaint: ☐ *Same as Complainant*

Name:		Telephone:		Cell Phone:	
Mailing Address:			Apartment, Suite, Room:		
City:		State:		Zip:	
Health Care Facility Transported To:			Patient Record#		

My Complaint is Related to the Organization Checked Below:

☐	Ground Ambulance	☐	Emergency Medical Care Technician	☐	ALS Base Hospital
☐	Air Ambulance	☐	Training Program	☐	Trauma Center

Name of the EMS Provider Organization Involved:			
❶ Name of the Emergency Medical Care Technician:		Certification Number:	
❷ Name of the Emergency Medical Care Technician:		Certification Number:	
❸ Name of the Emergency Medical Care Technician:		Certification Number:	
❹ Name of the Emergency Medical Care Technician:		Certification Number:	

My Complaint is described in detail in the expandable space below and describes what occurred to warrant this complaint. If applicable, I have attached all documents in my possession that may support my complaint. If additional sheets are needed to complete my description of the events, I have attached additional copies to this complaint or will mail them to the Bureau at the address provided.

Details: *(Expands as you type)* ➔

Date:	☐	**By checking the box to the left or affixing a signature below, I attest that all statements provided on this complaint form and in any supplemental documents submitted to the Bureau are true, accurate, and complete to the best of my knowledge and belief.** _____ **Complainant Signature**