LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
BUREAU OF EMERGENCY MEDICAL SERVICES
Certification Commission

COMPLAINT FORM

Submit to:
EMS Certification Commission
7173 Florida Blvd. Suite A
Baton Rouge, La 70806
Phone: (225) 925-7216
Fax: (225) 925-3832
Email: alan.lambert@la.gov

The EMS Certification Commission reviews complaints that an individual has engaged in, or is engaging in, any conduct proscribed by R.S. 40:1236.6, and the complaint may be made by any person, staff, agency, or the commission. Such complaints shall be made on this form, and shall have attached copies of all evidence to support the allegations. If your complaint appears to show the existence of a violation of the statutes or rules related to emergency medical services in Louisiana, an investigator may contact you for further information. Depending on the nature of the allegations, the complaint may be referred to another Department, Office, or state regulatory agency or board. Communications from the complainant shall be privileged and shall not be revealed to any person unless such documents will be offered for evidence in a formal hearing, or unless subpoenaed by a court, or requested by other regulatory agencies.

COMPLAINANT INFORMATION

Your Name/Company _____ Contact Number _____

Address _____

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

SUBJECT OF COMPLAINT

Complaint is filed against _____ National Registry Number _____

Subject Name _____ Contact Number _____

Address _____

Nature of Complaint (check all that apply)

- ☐ Quality of Care
- ☐ Practicing without certification / with expired certification
- ☐ Criminal Arrest/Conviction
- ☐ Sexual abuse / harassment or contact
- ☐ Falsifying records
- ☐ Failure to report
- ☐ Alcohol / drug abuse
- ☐ Violation of patient confidentiality
- ☐ Practicing beyond scope of certification
- ☐ Patient abandonment / neglect / abuse
- ☐ Misappropriating items of an individual / agency / entity
- ☐ Other (Please describe in narrative)

PATIENT INFORMATION (if applicable)

Patient Name _____ Contact Number _____

Address _____

Relationship of Complainant to Patient _____

By affixing an electronic signature below, I attest that all statements provided on this complaint form and in any supplemental documents submitted to the EMS Certification Commission are true, accurate, and complete to the best of my knowledge and belief.

Signature _____ Date _____

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Please describe in detail, in the space below, what occurred to warrant this complaint including: facts, details, locations, dates, times, witness (es) with contact information, etc. Please attach/submit copies of medical records, correspondence, contracts, newspaper articles, disciplinary reports, termination reports, drug screen results, and/or any other documents that will help support your complaint.