



OHIO DEPARTMENT OF PUBLIC SAFETY  
DIVISION OF EMERGENCY MEDICAL SERVICES

## COMPLAINT

**COMPLAINT AGAINST (Non-Emergency, Emergency, or Air Medical Service Organization):**

NAME OF SERVICE			
ADDRESS		CITY	STATE
PHONE NUMBER	DATE OF COMPLAINT	DATE OF INCIDENT	

**NOTICE TO COMPLAINANT:**

Pursuant to Ohio Administrative Code, 4766-2-16, 4766-3-16, 4766-4-16, and 4766-5-19, the Division of Emergency Medical Services may investigate alleged violations of Chapter 4766 of the Ohio Revised Code and the rules promulgated thereunder. If your complaint is determined not to be a violation of Chapter 4766, it may be forwarded to the appropriate agency.

**COMPLAINT FILED BY:** (Your complaint may be filed anonymously, however we can not provide a response to you without the following information.)

NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP

**DESCRIPTION OF COMPLAINT:** Describe the event, conduct, behavior and / or circumstance(s) you feel are a violation(s) of Chapter 4766. Provide as much detail as possible. Use additional sheets if needed.

**WITNESSES:** (List names, addresses and phone numbers of any witnesses who have knowledge of the event or improper conduct or may have other relevant information.)

NAME	PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP

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ADDRESS	CITY	STATE	ZIP

NAME	PHONE NUMBER		
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NAME	PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP

**SIGNATURE: (OPTIONAL)**

By signing this complaint, I attest that all the information provided is true to the best of my knowledge. I also acknowledge that I am willing to provide a sworn statement concerning this complaint.

SIGNATURE <b>X</b>	DATE
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**PLEASE MAIL COMPLETED FORMS TO:**

Ohio Department of Public Safety  
 Division of Emergency Medical Services  
 1970 West Broad Street  
 P.O. Box 182073  
 Columbus, OH 43218-2073

**Forms may also be faxed:**

Fax: (614) 466-9461