TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATIONS
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
TELEPHONE: (615) 741-2584

THE EMS COMPLAINT/ INVESTIGATION PROCESS

WHEN TO FILE A COMPLAINT

Tennessee has a high quality prehospital Emergency Medical Services (EMS) and medical transportation system. A large majority of licensed EMS personnel and ambulance services are competent and caring providers.

However, when a problem is experienced with an EMS provider, you have the right to file a complaint. If you believe that a provider's performance or professional behavior is not acceptable, you can file a complaint with the EMS Office.

STATE RESPONSIBILITIES

The EMS Office tests and licenses EMS personnel (EMRs, EMTs, Paramedics and EMDs) and ambulance services under state law and the rules of the State EMS Board. A related responsibility is reviewing and investigating complaints that allege violations of the law or rules.

When the investigation is completed and a determination is made by the EMS Office and an EMS Board representative that a significant violation has occurred, disciplinary action will be pursued. If the provider wishes to appeal such action he/she may request a contested case hearing before the EMS Board. The Board will hear the case and then make a decision on the matter, including any disciplinary action warranted if the respondent is found guilty of the violation(s) charged.

While the Department cannot assist you with civil or criminal matters, and does not represent you as an individual, EMS law allows the department to act on behalf of the people of Tennessee at large. The law gives the department and Board the power to control a provider's ability to practice in the state of Tennessee, but cannot levy criminal penalties or civil damages. Any person seeking to recover fees or monetary remedies for injuries should consult an attorney regarding those matters. The State of Tennessee has no jurisdiction over these types of situations.

FILING A COMPLAINT

While we hope that you will never have to file a complaint against an EMS provider, doing so is a simple matter. Please read the attached form carefully and fill it out. You are also requested, if you were the patient, to complete and sign a "Medical Records Release Form". While the form may not always be used, it is helpful to have this form in the event records are needed to determine course of treatment or actions that have been taken with regard to care provided. All materials received in connection with the complaint will become property of the Department of Health and cannot be returned.

Please return the complaint to:

TN Department of Health
Office of Emergency Medical Services
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
Attn: Complaint Intake

RESULTS

When a decision is finally reached, you will receive a letter from the EMS Office. The content of such letters varies depending upon the circumstances of the complaint, however, they are generally one of the following types.

(1) There was no violation of the Practice Act that would lead to disciplinary action, but the practitioner has been informed of any concerns determined by the investigation.

(2) There was a violation of the Practice Act and a formal disciplinary action was taken, made part of the public record, and reported statewide and to the national data bank.

The Department of Health takes all complaints seriously and insures that a thorough and fair evaluation under law is conducted.

ISSUES *NOT* WITHIN DEPARTMENT/BOARD AUTHORITY

- **Fees and/or Billing disputes** (Amounts charged for services, overcharges, etc.)
- **Insurance Matters** (unless it deals with fraud by an EMS provider)

For these concerns you should contact the State Consumer Affairs Division at 1-800-342-8385.

TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

COMPLAINT AND RELEASE INFORMATION

I. PART A

PERSON FILING COMPLAINT:

Name: _____

Address: _____
Street City State Zip

Personal Telephone: (_____) _____ Work Telephone: (_____) _____

YOU ARE FILING A COMPLAINT AGAINST:

(EMS provider's name, either person or service)

Name: _____
First Name - or Service Name Middle Last

Address: _____
Street City State Zip

Telephone: (_____) _____

License #: (if known) _____

NAME OF PATIENT (IF OTHER THAN YOURSELF): _____

Address: _____
Street City State Zip

Telephone: (_____) _____

Relationship of Person Filing Complaint to Patient:

☐ Self ☐ Parent ☐ Son/Daughter ☐ Legal Guardian/provide court documents
☐ Spouse ☐ Brother/Sister ☐ Friend
☐ Other _____

NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship.

Nature of Complaint/Report (check all that apply)*:

☐ Quality of care/Malpractice
☐ Insurance fraud
☐ Sexual Abuse; Harassment; Contact
☐ Criminal Conviction
☐ Unlicensed Practice
☐ Substance Abuse
☐ Drug Diversion
☐ Run Report Falsification
☐ Patient Abandonment/Neglect
☐ Problem other than listed _____

Have you attempted to contact the EMS provider concerning your complaint?

☐ Yes ☐ No If yes, Date: _____

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

* Employers please complete complaint form B as well.

COMPLAINT NARRATIVE

Is there anyone other than yourself that knows about your complaint and could give us further information?

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 medical records, correspondences, contracts, newspaper articles, and any other documents that will help support your complaint.

I certify that all information provided in this complaint is true and correct to the best of my knowledge.

Signature

Date

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: Any and all treating physicians or facilities

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, psychiatrist, psychologist, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, emergency personnel and other persons who have participated in providing any care or 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 Tennessee Department of Health, Office of EMS (or any official representative of the Office).

This document authorizes the loan of any of the aforementioned reports and information to the EMS Office (or any official representative of the Office) for reproduction, investigation or other use.

Patient Signature _____ Date _____

Social Sec. No. _____ Date of Birth _____

Authorized Person Other Than Patient _____ Relationship _____

Return to: _____

_____

_____

II. PART B

INSTRUCTIONS TO EMPLOYERS REPORTING PERSONNEL VIOLATING THE EMS PRACTICE ACT

Delays can be minimized when employers submit the supporting documentation along with the complaint. If, for whatever reason, that is not feasible, the employer should have all of the appropriate documentation at hand so that it can be provided to the investigators from the Office of Emergency Medical Services.

The EMS disciplinary process is guided by strict legal requirements. It is absolutely imperative that supporting documentation be provided in every disciplinary case. It is unlikely that an employer would take disciplinary action without documentation to support the decision. The same documentation is important to this agency in pursuing disciplinary action.

In cases of a drug screen done for cause: Please submit the laboratory report itself and the chain of custody form. We also need the documentation that formed the basis of the "cause" for the drug screen.

In cases of a positive, random drug screen: Please submit the laboratory report itself and the chain of custody form.

In cases of suspected drug theft: If an employer or provider discovers errors in administering or stocking controlled substances or legend drugs, we require the specific records for each occasion or discrepancy. The patient report form, copies of the physician's orders, and any controlled drug administration record or drug inventory record are required. In making copies of these documents, please assure that the document copies "from margin to margin" and does not cut-off important information.

In cases of suspected theft, or the misuse of medical devices: Please submit a narrative report of the suspected occurrence, any police reports of the theft of items or major equipment, and any patient care reports that might be related to the incident.

In cases of false reports: Provide certified copies of the documents that were falsified. Please do no highlight the fraudulent entry, but you may affix post-it notes. In cases where an act or procedure was recorded but was not performed, please provide another document to show the absence of the proper record entry.

Witness Statements: In many cases, written statements by other employees who witnessed all or part of an occurrence are important since these same individuals might be called upon to testify at a formal hearing. Please ensure that these statements are properly identified as to the author, the date the statement was written, and that they are legible and complete copies (margin to margin). An accompanying cover letter summarizing the documents described herein should also identify these possible witnesses by full name, address and job title, and professional license credentials.

Documentation in these cases may vary somewhat according to the service or facility as well as the circumstances. The description of documents may also vary in title or form, but should provide the same generic information.

EMPLOYER'S REPORT OF POSSIBLE VIOLATION

FULL NAME OF THE EMS PROVIDER BEING REPORTED:

_____

PROVIDER'S PROFESSION (i.e. EMT, Paramedic): _____ LIC #: _____

SOCIAL SECURITY #: _____

LOCATION WHERE OFFENSE OCCURRED: _____

DATE OR CUMULATIVE DATES OF OCCURRENCE: _____

PROVIDER'S POSITION OR TITLE: _____

PROVIDER'S IMMEDIATE SUPERVISOR: _____

CUMULATIVE DATES OF EMPLOYMENT: FROM _____ **TO** _____

CURRENT STATUS OF EMPLOYMENT: _____

NAME OF SERVICE DIRECTOR: _____

ADDRESS: _____
Street City State Zip

TELEPHONE: (_____) _____ **FAX:** (_____) _____
PLEASE PROVIDE DIRECT NUMBERS AND ANY EXTENSIONS

E-MAIL ADDRESS: _____

NAME AND TITLE OF INDIVIDUAL FILING THIS REPORT:

_____

NATURE OF COMPLAINT/REPORT: (CHECK ALL THAT APPLY)

- ☐ QUALITY OF CARE/MALPRACTICE
- ☐ EQUIPMENT THEFT
- ☐ SEXUAL ABUSE, HARRASSMENT OR CONTACT
- ☐ CRIMINAL CONVICTION
- ☐ PATIENT ABANDONMENT/NEGLECT
- ☐ SUBSTANCE ABUSE
- ☐ INSURANCE FRAUD
- ☐ DRUG DIVERSION
- ☐ UNLICENSED PRACTICE
- ☐ RUN REPORT FALSIFICATION
- ☐ PROBLEM OTHER THAN LISTED ABOVE _____

NAME, TITLE AND MAILING ADDRESS OF THE RECORDS CUSTODIAN:

_____

_____

WAS A DRUG SCREEN PERFORMED? ☐ Yes ☐ No

TYPE OF SCREEN (urine, serum, etc.) _____

DATE/TIME OF SPECIMEN COLLECTION _____

WAS CHAIN OF CUSTODY FOLLOWED? _____

NAME OF TESTING LAB _____

FULL NAME AND TITLE OF THE INDIVIDUAL COLLECTING THE SPECIMEN:

_____

LIST THE SPECIFIC SECTION OF THE APPROPRIATE TENNESSEE PRACTICE ACT AND THE TENNESSEE BOARD REGULATIONS THAT YOU BELIEVE HAVE BEEN VIOLATED:

_____

IDENTIFY BY TITLE ALL ACCOMPANYING DOCUMENTATION AND IT'S RELEVANCE (PLEASE NOTE BUT DO NOT HIGHLIGHT RELEVANT INDIVIDUAL ENTRIES)

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

15) _____

16) _____

17) _____

18) _____

19) _____

20) _____

21) _____

22) _____

23) _____

24) _____

25) _____

(USE ADDITIONAL SHEETS IF NECESSARY)

PREVIOUS DISCIPLINARY (COUNSELING) ACTIONS:

DATE: _____

NATURE OF THE OFFENSE: _____

ACTION TAKEN: _____

PREVIOUS DISCIPLINARY (COUNSELING) ACTIONS:

DATE: _____

NATURE OF THE OFFENSE _____

ACTION TAKEN: _____

WITNESS: _____
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET CITY STATE

TELEPHONE: ( ) _____

WITNESS: _____
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET CITY STATE

TELEPHONE: ( ) _____

WITNESS: _____
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET CITY STATE

TELEPHONE: ( ) _____

WITNESS: _____
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET CITY STATE

TELEPHONE: ( ) _____