



**State of New Mexico
Emergency Medical Systems Bureau
Complaint Form**



MAIL, FAX, OR E-MAIL COMPLETED FORM TO:

NEW MEXICO DEPARTMENT OF HEALTH
ATTN: EMS ENFORCEMENT SECTION
Emergency Medical Systems Bureau
1301 Siler Rd., Building F
Santa Fe, New Mexico 87507

Office: 505-476-8246
Fax: 505-471-2122
Email: solange.pihut@state.nm.us

(DO NOT FILL IN, BUREAU USE ONLY)

DATE COMPLAINT FORM RECEIVED:

DATE REFERRED FOR INVESTIGATION:

This form may be used to submit a complaint regarding an Emergency Medical Technician, Emergency Medical Dispatcher, EMS Service (Ground & Air), EMS Training Program, or EMS Instructor. Please submit the completed form to the mailing address or fax number displayed above. If your complaint appears to show a violation of the statutes or rules related to Emergency Medical Systems in New Mexico, an investigator will contact you for further information during the course of the investigation process. Depending on the nature of the complaint, the complaint may be referred to another Department office or to another state regulatory agency or board.

**EMERGENCY MEDICAL SYSTEMS
COMPLAINT FORM**

Name of person making complaint: _____

Mailing address of person making complaint: _____

City, State, Zip of person making complaint: _____

Phone number(s) of person making complaint: _____

E-mail address of person making this complaint: _____

Your Relationship to the subject of complaint (Patient, Family of Patient, Coworker, Employee, Employer, Receiving Facility, Bystander):

Licensee or EMS Service Name (Alleged Violator): _____

License Type: (Emergency Medical Technician (EMSFR, Basic, Intermediate, Paramedic),
Emergency Medical Dispatcher, EMS Service (Air & Ground), Training Program, Instructor):

Alleged violator's employer (if known): _____

Alleged violator's physical address (if known): _____

Alleged violator's City, State, Zip (if known): _____



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Alleged violator's phone numbers (if known): _____

Date of incident: _____

Patient Name (if applicable): _____

Patient record number (if known): _____

Your Relationship to the patient (if applicable): _____

Names of Witness #1: _____

Witness #1 Address: _____

Witness #1 Phone Numbers: _____

Names of Witness #2: _____

Witness #2 Address: _____

Witness #2 Phone Numbers: _____

Questions to be addressed in the narrative:

1. What happened, who was involved (i.e. staff, family, visitors, other patient(s), bystanders, etc)?
2. Are there any witnesses to the incident? (If so, List names, addresses and phone numbers.)
3. Did you report your concerns to the EMS service provider or its EMS staff? (If so, List names, addresses.)
4. Are law enforcement agencies involved? (If so, List names and office locations and names of agents spoken to.)
5. Are any other state agencies involved? (If so, List names and office locations and phone numbers of agents spoken to.)
6. Did the Emergency Medical Provider try to help you resolve the issues? (If so, describe its response.)
7. Do you have knowledge that any similar incidents have happened before? (If so, describe in detail those events, including specific times, dates, locations, names of witnesses, how you become aware of the incidents, etc.)

Note: This Department does not have regulatory authority over EMS charges or billing disputes.

NARRATIVE (Enter as much Narrative as Needed)
