



UTAH DEPARTMENT OF
HEALTH

Bureau of Emergency Medical Services and Preparedness
Complaint Compliance and Enforcement Unit

Complaint supplemental for agencies

Instructions for agencies filing complaints against personnel or another agency or entity:

One of the goals of the CCEU is to enhance patient care and to protect future patients and the public in general. Complaints cover a wide range of areas and each one will be given the necessary attention to make sure that it is properly and professionally handled. Your agency will be treated with respect and professionalism and we would ask for that in return.

This form will be filled out anytime the original complaint form is being submitted by an agency instead of a person. The complaint may be about one of your own personnel or it may be something that involves actions of another entity. Delays can be caused by a lack of information or missing detail so please be thorough and complete as many areas of this form as possible. Supporting documentation should be submitted with this complaint at the time of submission whenever possible. Many times an agency may have completed an internal investigation, even though we may start all over with interviews it would be very helpful to have the information from your investigation. We will begin the investigation by policy within 2 business days of receiving the complaint in our office. An Investigator will be assigned and your agency contacted.

On the original complaint there are areas that are left vague on purpose. In this supplemental report you will find detailed sections for witnesses and documents please take the time to get as much detail in there as possible. As an agency you should have much better access to this information than the general public. This will greatly speed up our ability to respond to this complaint, bringing everyone involved a quicker resolution.

Our investigators and staff look forward to working with you and your agency. Do not hesitate to contact the office if you have questions about our process. We ask you to be understanding to the fact that while an investigation is underway we may be reluctant to discuss many details or speculate as to the outcome until completed. This is to protect all parties and to assure that the investigation is thorough and that all the proper information is acquired, reviewed, and properly evaluated. Upon completion of the investigation the case along with recommendations will be forwarded to the director, it may take some time to get a decision on the repercussions. Depending on the case we may be delayed by reviews from the bureau medical director, attorneys, and administration. We will do everything to speed up the process to get closure as soon as possible for all those involved. Thank you for what you do and for taking the time to submit your complaint and documentation.



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Supplemental report

Person or entity the complaint is about: _____

Agencies title or license acted under: _____ License # _____

Location where offense occurred: _____

Date or cumulative dates of occurrence: _____

Position or title of offender: _____

Immediate supervisor of offender: _____

Cumulative dates of employment if person: From _____ To _____

Current status of employment if person: _____

Name of agency director: _____

Address: _____
Street City State Zip Code

Telephone: _____ Fax: _____

E-Mail Address: _____

Name and title of person filing this complaint: _____

Name, title and mailing address of the records custodian:

Was a drug screen performed?: Yes No

Type of screen: _____

Date and time of specimen: _____

Was chain of custody followed and where is it stored: _____

Name and location of testing lab: _____

Name and title of person collecting specimen: _____

List specific violations that you feel have been violated and warrant investigation: _____

Signature of Complainant: _____ Date: _____

Previous disciplinary or counseling actions (if a person):

Date: _____

Nature of the offense: _____

Action taken: _____

Date: _____

Nature of the offense: _____

Action taken: _____

Witnesses:

Name: _____

First

Middle

Last

Home address: _____

Street

City

State

Zip Code

Telephone #s: _____

Name: _____

First

Middle

Last

Home address: _____

Street

City

State

Zip Code

Telephone #s: _____

Name: _____

First

Middle

Last

Home address: _____

Street

City

State

Zip Code

Telephone #s: _____

Name: _____

First

Middle

Last

Home address: _____

Street

City

State

Zip Code

Telephone #s: _____

Name: _____

First

Middle

Last

Home address: _____

Street

City

State

Zip Code

Telephone #s: _____

Signature of Complainant: _____ **Date:** _____