

Mission :

To protect, promote and improve the health of all people in Florida through integrated state, county & community efforts.



Vision:

To be the Healthiest state

BUREAU OF EMERGENCY MEDICAL OVERSIGHT
Emergency Medical Services Section
Investigation Unit
COMPLAINT FORM

Please Return To: Bureau of Emergency Medical Oversight
c/o Emergency Medical Services Section
Investigation Unit
4052 Bald Cypress Way, Bin A22
Tallahassee, Florida 32399-1722

The Department of Health Bureau of Emergency Medical Oversight (BEMO) is responsible for investigating complaints involving service providers, training schools and 911 Public Safety Telecommunicators.

To file a complaint/report, compete, sign and notarize or witness this form and provide dates and details regarding your complaint.

Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint. The Authorization for Release of Patient Information form included on page 4 must be completed and signed in order to process your complaint, as a health care practitioner cannot even disclose that you are his/her patient without this authorization (if applicable).

The Department will acknowledge receipt of your complaint/report by letter. If the allegations contained in your complaint are determined to be possible violations of applicable laws and rules, your complaint will be assigned for investigation.

If you have questions about the complaint process, contact the BEMO's Investigation Unit at (850) 2454440.

ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT/BUREAU OF EMO INCLUDE:

- **Fee or Billing disputes (i.e., the amount a provider charges for services).**
- **Rudeness or personality conflicts (i.e., provider or staff's attitude or professionalism).**

Health care practitioners are regulated by professional boards under the purview of the Department and the action which may be taken by the professional boards is administrative in nature (i.e., reprimand, fine, restriction of practice, remedial education, administrative cost, suspension, or revocation). The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters. The Department is not a law enforcement agency. If you believe this complaint may be a crime, please report it to your local law enforcement agency immediately.

COMPLAINANT/REPORTER:

Your Name/Company: _____

Address: _____

(Street)

(City)

(State)

(Zip)

Telephone: _____

(Home)

(Work)

SUBJECT OF COMPLAINT/REPORT:

Provider's Name/Training Name: _____

Address: _____

(Street)

(City)

(State)

(Zip)

Telephone: (____) _____

(Home)

(Work)

Profession: _____ (i.e., ALS, BLS, Air, Training School or 911 PST)

License #: _____

Name of Patient if other than yourself: _____ Address
of Patient if other than yourself:

(Street) (City) (State) (Zip)

Telephone: (____) _____ Relationship of

Complainant to Patient:

- Self Patient Son/Daughter Legal Guardian (provide documentation)
 Spouse Brother/Sister Friend Other Physician _____
 Other _____

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

Nature of Complaint (check all that apply)

- Quality of care Misfilled/mislabeled prescription
 Operating without a license Failure to release patient records
 Failure to provide true information Patient abandonment/neglect
 Insurance fraud Advertising violation
 Failure to report
 Operating beyond scope of license
 Employing a non-Florida certified EMT/ Paramedic/ 911 Public Safety Telecommunicator
 Problem other than listed above _____

Have you attempted to contact the provider concerning your complaint? YES NO

Date: _____

Would you be willing to testify if this matter goes to a formal hearing? YES NO If the incident complained of involved criminal conduct, you should contact your local law enforcement authority.

Have you contacted your local law enforcement authority? YES NO

If yes, state the name of the person or office that you contacted: _____

When did you make this contact? _____

Please give case number if available: _____

Please list any prior and/or subsequent treating practitioners relative to your complaint (please give full name, address and telephone number).

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 medicals records, correspondence, contracts, and any other documents that will help support your complaint.

What would satisfy your complaint?

Section 837.06, Florida Statutes, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature (required to file complaint)

Date

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: Any and all treating health care practitioners or facilities

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA Privacy Law) found at 45 CFR, Part 164.

A photocopy of this document is as sufficient as the original

This document authorizes any and all licensed health care practitioners, including but not limited to: Physicians, nurses, therapists, social workers, counselors, dentist, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants, and other person who have participated in providing any health care 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 Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.

This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use of licensure or disciplinary actions, and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation. This authorization is in effect until related disciplinary proceedings are concluded.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Please Print)

Patient Signature

DOB

Social Security number

Name of Authorized Person Other than Patient (Please Print)

Relationship

Signature of Authorized Person Other than Patient

STATE OF _____ COUNTY OF _____

Before me, personally appeared _____

Whose identity is known to me by _____

(type of identification) and who, acknowledges that his/her signature appears above.

Sworn to or affirmed by Affiant before me this _____ day of _____, 20____

NOTARY PUBLIC

My Commission Expires

Name (Please PRINT)

Witness Signature (if not notarized)