



THE COUNTY OF CHESTER



COMMISSIONERS
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EMS INCIDENT/COMPLAINT FORM

DATE OF INCIDENT _____ TIME _____

AGENCY / INDIVIDUAL INVOLVED _____

ORGANIZATION FILING COMPLAINT _____

ADDRESS _____

TELEPHONE NUMBERS _____

INDIVIDUAL / REPRESENTATIVE FILING _____

POSITION _____

HAS CONTACT BEEN MADE WITH OTHER INVOLVED PARTIES? YES _____ NO _____

IF YES, WAS A RESPONSE RECEIVED? YES _____ NO _____

IF YES, WHEN? _____

WHAT WAS THE RESPONSE? (attach copy if applicable)

NARRATIVE (use chronological order with times if applicable)

SIGNATURE _____ DATE _____

(attach additional sheets if necessary)

OFFICE USE ONLY: CCEMS QA CONTROL # _____

DOH CASE # _____

RECEIVED _____ DATE _____

REVIEWED BY _____ DATE _____

FORWARDED TO PA DOH EMS YES _____ NO _____ DATE _____

FORWARDED BY _____ DATE _____

REVIEWED AT DOH BY _____ DATE _____

RECOMMENDED ACTION _____
