



# Delaware County Emergency Medical Services

## Complaint Record Form

Name of Person Filing Complaint: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Complaint Received By:  - Person  - Phone  - Letter (attached)

Date Received: \_\_\_\_\_ Time: \_\_\_\_\_

Received by: \_\_\_\_\_

Nature of Complaint, Using the Words of the Complainant (attach additional pages to this form):

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Referred to: \_\_\_\_\_ Date: \_\_\_\_\_

Report of Investigation: (attach additional pages to this form):

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Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Final Disposition: (attach supporting documentation to this form):

- Unfounded  - Exonerated  - Not Sustained  - Sustained

Investigator - Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Chief - Signed: \_\_\_\_\_ Date: \_\_\_\_\_