

**Commonwealth of Virginia
Virginia Office of Emergency Medical Services**



Virginia Office of Emergency Medical Services
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COMPLAINT REPORT FORM

Person Supplying Information

NAME (FIRST, MIDDLE, LAST)		
BUSINESS NAME (IF APPLICABLE)		HOME PHONE
STREET ADDRESS		WORK PHONE
CITY/COUNTY	STATE	ZIP
		E-MAIL ADDRESS

Subject of Report (EMS AGENCY/TECHNICIAN)

NAME (FIRST, MIDDLE, LAST)		TITLE
BUSINESS NAME (IF APPLICABLE)		HOME PHONE
STREET ADDRESS		WORK PHONE
CITY/COUNTY	STATE	ZIP
		VEHICLE UNIT NUMBER

For Departmental Use Only

CASE NUMBER	NATURE						
LICENSE NUMBER	EXP. DATE	POSSIBLE VIOLATION (CITE STATUTE OR REG)					
CSRC NO./ADDITIONAL LICENSE	EXP. DATE						
REPORTED TO:			RECEIVED BY				
PRIORITY	INVEST	REGION					
NAME OF AGENCY/TECHNICIAN INVOLVED				LICENSE/CERTIFICATION NUMBER			
DATE OF COMPLETION							

