DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00567 (08/2025)

STATE OF WISCONSIN
Office of Preparedness and Emergency Health Care
Wis. Stats. § 256
608-266-1568

EMERGENCY MEDICAL SERVICES COMPLAINT

This form is required for those individuals interested in filing a complaint against a licensed emergency medical services personnel, service, or EMS training center. If you believe a violation of Wis. Stat. ch. 256 or Wis. Admin. Code ch. DHS110 has occurred you may complete this form and submit to the Wisconsin EMS Section for investigation and disposition. Return this completed form and necessary attachments via email to DHSEMSINV@dhs.wisconsin.gov or via USPS to: Wisconsin Department of Health Services, Complaints & Investigations, WI EMS Section, 201 E. Washington Ave., PO Box 2659, Madison, WI 53701-2659.

COMPLAINT AGAINST

Last Name	**First Name**	**MI**

Ambulance Service Name / Training Center Name

Mailing Address

City	**State**	**Zip Code**	**County**	**Telephone Number**

License Number (If Known)	**License Level (If Known)**

FILED BY

Last Name	**First Name**	**MI**

Company Name

Mailing Address

City	**State**	**Zip Code**	**County**	**Telephone Number**

RELATIONSHIP TO PATIENT

☐ Self ☐ Parent ☐ Son / Daughter ☐ Legal guardian (Provide court documents) ☐ Spouse
☐ Brother / Sister ☐ Friend ☐ Other (Please specify)

Please 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 ☐ Insurance fraud ☐ Sexual abuse, harassment or contact
☐ Criminal Conviction ☐ Substance abuse ☐ Drug diversion ☐ Run report falsification
☐ Patient abandonment/neglect ☐ Unlicensed practice ☐ Other than listed (Please specify)

Please note: If other than patient or parent of minor patient, please provide documentation indicating appointment of legal authority / guardianship.

Have you attempted to contact the EMS provider concerning your complaint?
☐ Yes ☐ No Date
What was their response to your complaint?

Would you be willing to testify if this matter goes to formal hearing? ☐ **Yes** ☐ **No**

WITNESS 1

Last Name	First Name	MI

Mailing Address

City	State	Zip Code	County	Telephone Number

WITNESS 2

Last Name	First Name	MI

Mailing Address

City	State	Zip Code	County	Telephone Number

WITNESS 3

Last Name	First Name	MI

Mailing Address

City	State	Zip Code	County	Telephone Number

WITNESS 4

Last Name	First Name	MI

Mailing Address

City	State	Zip Code	County	Telephone Number

WITNESS 5

Last Name	First Name	MI

Mailing Address

City	State	Zip Code	County	Telephone Number

COMPLAINT

In the space below, please provide the pertinent information regarding the complaint. Provide names, dates, times, places, and as much detail as possible of the event.

What remedy / result are you seeking / expecting? Please describe below:

By submitting this application you are affirming that all statements you have made in this document are true. You understand that the EMS Section has the right to determine what action will be taken and if a full investigation is warranted.

Name and / or Signature of Person filing complaint	**Date**

Form May Be Mailed To:

SEND FORM VIA EMAIL:

DHSEMSINV@dhs.wisconsin.gov

OR

Wisconsin Department of Health Services
Complaints & Investigations
WI EMS Section
201 E. Washington Ave.
PO Box 2659
Madison, WI 53701-2659