



REGION 11 EMS REQUEST FOR CLARIFICATION (RFC) OR COMPLAINT FORM

CONFIDENTIAL

THIS IS A CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT.
DO NOT COPY OR MAKE REFERENCE TO ITS COMPLETION IN THE MEDICAL RECORD/PATIENT CARE REPORT.

Date and Time of Occurrence: _____

EMS Agency and Unit Number: _____ Event or Incident Number: _____

Hospital or Facility Where the Patient Was Transported: _____

Hospital Log or Report Number: _____

EMS Personnel Name(s): _____

Names of the Patient, Entities, Family Members, and Other Persons Involved:

Relationship of the Complainant to the Patient or the Provider: _____

Patient Condition and Status: _____

Details of the Situation:

Name of Person(s) Submitting Form:

Form Submitted To: _____

Date Form Submitted: _____

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