CITY OF CLEVELAND
Mayor Frank G. Jackson

City of Cleveland
Division of Emergency Medical Service
Comment Form

Cleveland EMS
EMERGENCY MEDICAL SERVICE

Instructions: Please provide as much information as possible. This form can be filled-in either online or printed then filled-in by hand. This form can be submitted via mail, email, or fax:

City of Cleveland
Division of Emergency Medical Service
Attn: Office of Professional Standards
1701 Lakeside Ave
Cleveland, Ohio 44114

Email: EMSFeedback@city.cleveland.oh.us

Fax: (216) 623-4599

The following information is being submitted to Cleveland EMS as (select one):

- ◯ A compliment regarding an interaction with EMS personnel
- ◯ A complaint regarding an interaction with EMS personnel

Person Submitting the Information:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____

Interaction Details:

IF YOU WERE NOT THE PATIENT, PLEASE INDICATE THE PATIENT'S NAME AND PHONE NUMBER:

YOUR RELATIONSHIP TO THE PATIENT:

DATE AND TIME OF INTERACTION:

AMBULANCE NUMBER:

LOCATION OF INTERACTION WITH EMS CREW:

NAME(S) AND/OR BADGE NUMBER(S) OF EMS PERSONNEL, IF KNOWN

DETAILED DESCRIPTION OF INTERACTION:

If you are filing a complaint, please provide additional information as indicated below:

Convenient time of day for you to be interviewed: ◯ **Morning** ◯ **Afternoon** ◯ **Evening**

If there were other witnesses to this incident, enter the names and daytime phone numbers of up to five other person(s) that can verify this complaint:

Witness Name/Phone No: _____

Witness Name/Phone No: _____

Witness Name/Phone No: _____

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