**Oregon Department of Human Services**
**Emergency Medical Services & Trauma Systems Section**

# Agency Reportable Actions

*In accordance with ORS 682.220 (4) and/or OAR 333-250-0043 must be reported to Division* ***within 14 days of occurrence***

*Agency must complete applicable sections of this page.*

**NAME of EMPLOYEE**:_____
Last First MI

□ First Responder □ Basic □ Intermediate □ Paramedic CERT# _____

**NEW EMPLOYEE or MEMBER**

Date of Hire: _____Position/Title: _____
Status: □ Paid Full Time □ Paid Part Time □ Volunteer

**EMPLOYMENT STATUS CHANGE**
Effective Date: _____
Reason: □ Retirement □ Resignation □ Termination
□ Resignation in lieu of discipline □ Layoff □Leave of Absence
□ Deceased □ Other _____

**PHYSICAL or MENTAL HEALTH CHANGES** (Attach a complete explanation and/or medical records if applicable)

□ Development of any physical disability that affects the certificate holder's ability to perform the duties of a First Responder/EMT, **AND** the certificate holder continues to respond to calls or is providing patient care.

□ Any changes in mental health which may affect the ability to perform as a certified First Responder or EMT

**ACTION by AGENCY or SUPERVISING PHYSICIAN** (Attach a complete explanation)
Effective Date:_____ If Temporary Ending Date:_____
Reason: □ Termination □ Suspension □ Administrative Action
□ Standing Orders Revoked □ Disciplinary Scope of Practice Restriction
□Other: _____
_____
□ Ambulance Collision: (Please attach DMV report)

**REPORTING AGENCY INFORMATION**

Reporting Agency:_____

Reporting Officer:_____
Full Name Title Phone #

I certify that the information on this form has been verified and is substantiated by records maintained by this agency.

_____ _____ _____
Signature Title Date

*Return completed and signed form to: EMS Section, PO Box 14450, Portland, OR 97293-0450 or Fax to 971-673-0555 Attn: EMS Section*
*ems.trauma@state.or.u*

**Oregon Department of Human Services**
**Emergency Medical Services & Trauma Systems Section**

# EMT/First Responder Reportable Actions

*In accordance with OAR 333-250-0160 and 333-265-0080 must be reported to the Division* ***within 14 days of occurrence***

**NAME:** _____
Last First MI

□ First Responder □ Basic □ Intermediate □ Paramedic CERT# _____

**CHANGE TO ANY OF THE FOLLOWING**

□ Name – Attach a copy of Court order or certificate of marriage

□ New Mailing Address: _____
City: _____ State _____ Zip _____ County_____

□ Telephone number(s) Work _____ - _____ - _____ Home _____ - _____ - _____

□ Agency Affiliation:
Agency: _____ □ Add □ Delete
Status: □ Paid Full Time □ Paid Part Time □ Volunteer
Agency: _____ □ Add □ Delete
Status: □ Paid Full Time □ Paid Part Time □ Volunteer
Agency: _____ □ Add □ Delete
Status: □ Paid Full Time □ Paid Part Time □ Volunteer

□ Non-Affiliated with an agency as an EMT/First Responder in Oregon
□ No Supervising Physician
□ Supervising Physician Name: _____

**PHYSICAL or MENTAL CHANGES** (Must attach a complete explanation and/or medical records if applicable)

□ Development of any physical disability that affects the certificate holder's ability to perform the duties of an EMT, **AND** the certificate holder continues to respond to calls or is providing patient care.

□ Any changes in mental health which may affect the ability to perform as a certified First Responder or EMT

**OTHER REPORTABLE ACTIONS** (Must attach a complete explanation)

□ Disciplinary restriction on Scope of Practice

□ Defendant in a lawsuit alleging malpractice or misconduct

□ A citation, arrest, formal charge, or conviction of a crime. (Minor traffic violations need not be reported)

□ Participation in a DUII diversion program

□ Restriction or loss of driving privileges

□ Admission to drug or alcohol treatment program

□ Admission to a mental health treatment facility

I certify the information on this form is true and correct to the best of my knowledge. I understand I may be subject to discipline, including suspension, revocation, probation or civil monetary penalty for making false statements in connection with my certification.

_____ _____ _____
Signature Title Date

*Return completed and signed form to: EMS Section, PO Box 14450, Portland, OR 97293-0450 or Fax to 971-673-0555 Attn: EMS Section*
*Email: ems.trauma@state.or.us*