



Agency Reportable Actions

Please complete the applicable sections of this form and submit it to the Oregon Health Authority EMS and Trauma Systems Office. Licensed EMS agencies are required to submit this information in accordance with ORS 676.150, 682.025, 682.220(4) and/or OAR 333-250-0043.

Name of employee:

Last name: _____ First name: _____ Middle initial: _____
 EMR EMT AEMT Intermediate Paramedic License #: _____

New employee/member: REPORT WITHIN 14 DAYS

Date of hire: _____ Position/title: _____
Status type: Paid – full time Paid – part time Volunteer

Employee status change: REPORT WITHIN 14 DAYS

Effective date: _____ Reason: _____
Other details: _____

Physical or mental changes: REPORT WITHIN 10 DAYS

(Please attach a complete explanation and/or medical records, if applicable.)

- Development of any physical disability that affects the license holder's ability to perform the duties of an EMS Provider and the EMS Provider continues to respond to calls or is providing patient care.
- Any changes in mental health which may affect the ability to perform as a licensed EMS Provider.

Action by agency or EMS Medical Director: REPORT WITHIN 10 DAYS

Effective date: _____ If temporary, ending date: _____
Reason: _____
Other details: _____

Reporting agency information:

Reporting agency (<i>print</i>)	Agency number	
Reporting officer (<i>print</i>)	Title	Phone
Signature	Date	

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

If this document contains confidential and/or privileged information, please print and mail to: EMS Section, PO Box 14450, Portland, OR 97293-0450 or via secure fax to: 971-673-0555. Electronic mail cannot be guaranteed secure. Email address is: ems.trauma@state.or.us