PUBLIC HEALTH DIVISION
Emergency Medical Services and Trauma Systems

EMS Provider Reportable Actions

Oregon Health Authority

Please complete the applicable sections of this form and submit it to the Oregon Health Authority EMS and Trauma Systems Office. This information is required in accordance with ORS 676.150, 682.025, 682.220 and OAR 333-265-0080, 333-265-0083, 333-265-0160.

Name: REPORT WITHIN 30 DAYS

Last name: _____ First name: _____ Middle initial: _____

☐ EMR ☐ EMT ☐ AEMT ☐ Intermediate ☐ Paramedic License #: _____

Change to any of the following: REPORT WITHIN 30 DAYS

☐ Name: _____ *(Please attach a copy of Court Order or Certificate of Marriage)*

☐ New mailing address: _____

☐ City: _____ State: _____ ZIP: _____ County: _____

☐ Work phone: _____ Home phone: _____

☐ Agency affiliation: _____ Email: _____

Choose one Agency name: _____ Status: **Choose one**

Choose one Agency name: _____ Status: **Choose one**

☐ Non-affiliated with an agency as an EMS Provider in Oregon

☐ No EMS Medical Director

☐ EMS Medical Director Name: _____

Other reportable actions: REPORT WITHIN 10 DAYS

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

Prohibited, dishonorable, unprofessional conduct or practice contrary to recognized standards of ethics as defined in ORS 676.150, 682.025 and 682.220 and OAR 333-265-0083.

☐ A felony arrest ☐ A felony conviction ☐ A misdemeanor conviction

☐ A disciplinary restriction placed on Scope of Practice by EMS Medical Director

☐ A legal action filed which alleges medical malpractice or misconduct

☐ 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

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 license.

Signature: _____ Date: _____

Reference state or federal laws relating to confidentiality or the protection of health information that might prohibit an EMS Provider from reporting prohibited or unprofessional conduct.
OAR 333-265-0080(4)

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

Save as Reset Print