



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.us



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