

## 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 Resp	oonder   Basic	□ Intermediate	□ Paramedic	CERT#				
NEW EMPLOYEE or MEMBER								
	D :17 11 m:	Position/Ti	tle:					
Status:	□ Paid Full Time	□ Paid Part Time	□ Volunteer					
ENADY OXZACENIO CIDA DELIC CITA NICIE								
EMPLOYMENT STATUS CHANGE  Effective Date:  Reason:   Resignation   Termination								
Reason:	□ Retirement	□ Resignation	□ Termination	1				
	□ Resignation in lie	u of discipline	□ Layoff	□Leave of Absence				
	□ Deceased							
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, <b>AND</b> the certificate holder continues to								
			<b>D</b> the certificate	holder continues to				
	nd to calls or is provid		a ability to parfa	rm as a partified First				
Any changes in mental health which may affect the ability to perform as a certified First Responder or EMT								
resp	onder of Livii							
ACTION by	AGENCY or SUPE	RVISING PHYSICIA	N (Attach a con	nplete explanation)				
Effective Da	te:	If Temporary E	nding Date:	1 1 /				
Reason:	□ Termination	If Temporary E  □ Suspension	□ Administrat	ive Action				
☐ Standing Orders Revoked ☐ Disciplinary Scope of Practice Restriction								
Other:								
DEDODTIN	C ACENCY INFOR	MATION						
REPORTING AGENCY INFORMATION								
Reporting As	gency:							
	5 <b></b> -							
Reporting Of	fficer:							
T C d	Full Name	Title	1 1: 1	Phone #				
•		s form has been verifie	a and is substant	nated by records				
mannamed b	y this agency.							
<u> </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

NAM	<b>IE:</b>							
	Last		First		MI			
□ Fir	st Responder	□ Basic	□ Intermediate	□ Paramedic	CERT#			
CHA	CHANGE TO ANY OF THE FOLLOWING							
	□ Name – Attach a copy of Court order or certificate of marriage							
	New Mailing	g Address:		C				
	City:		State Z	ipCo	unty			
	Telephone no	umber(s) Work		Home	unty			
	Agency Affi	liation:						
	Agency:		`ime □ Paid Pa		□ Add □ Delete			
	Agency:		ime □ Paid Pa		□ Add □ Delete			
	Statu	s: □ Paid Full T	`ime □ Paid Pa	rt Time □ Vol	unteer			
	Agency:	D : 1 E 11 T	ime □ Paid Pa	·				
	Statu	s: $\square$ Paid Full 1	ime   Paid Pa	rt Time 🗆 Vol	unteer			
			cy as an EMT/First	Responder in Oreg	gon			
		vising Physician						
	□ Supervisii	ng Physician	Name:					
			~~~~		, ., .			
PHY			GES (Must attach a	complete explana	tion and/or medical			
	records if ap	,	1 1: 1:1: 1		11 2 1:1:, ,			
		Development of any physical disability that affects the certificate holder's ability to perform the duties of an EMT, <b>AND</b> the certificate holder continues to respond to calls or						
			11, AND the certific	ate noider continu	es to respond to calls or			
	is providing	•	th which may affect	the chility to perfe	orm as a partified First			
	Responder of		ili wilicii illay affect	the ability to perio	orm as a certified First			
	ixesponder of	I LAVI I						
ОТИ	ED DEDODT	ADI E ACTIO	NC (Must attach a	aamnlata avnlanat	ion)			
			NS (Must attach a	complete explanat	.1011)			
	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								
connec	connection with my certification.							
<u> </u>								
Signatur	e		Title		Date			