

COMPLAINT FORM

Date of Incident: _____ Location of Incident: _____

Name: _____

Address: _____

Phone: _____

Complaint / Issue: _____

CONTINUE ON BACK IF NEEDED

Persons Involved:

Signature: _____ Date: _____

EAAS FOLLOW-UP:

Date Received: _____ Date Resolution Letter Sent: _____

Parties Investigating Complaint: _____

MAIL TO: ELY AREA AMBULANCE SERVICE
PO BOX 629
ELY, MN 55731