

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET

SACRAMENTO, CA 95814-7043

(916) 322-4336 FAX (916) 324-2875



(Date)

(Name of Complainant)

(Name of Agency, if applicable)

(Address)

Re: EMSA Complaint # _____, Paramedic (name)

Dear Mr./Ms. (name):

This letter acknowledges receipt of your referral of a matter concerning the above paramedic to the Emergency Medical Services Authority. We will be reviewing the matter and may request your assistance in obtaining additional information.

If you have any questions concerning this matter, please call A [REDACTED] at [REDACTED] extension [REDACTED]

Sincerely,

[REDACTED]

(Name of Chief)

Chief Investigator

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811-7043
(916) 322-4336 FAX (916) 445-0300



(Date)

(Name of Respondent)
(Address)

RE: Complaint Investigation Case #

Dear Mr./Ms. (Name of Respondent):

The Emergency Medical Services Authority (EMSA), Enforcement Unit, has received a complaint against you regarding potential violations of the California Health and Safety Codes. Pursuant to Section [REDACTED] Code, EMSA has initiated an investigation into the allegation that on or about (date), you (state allegation). As part of this investigation, EMSA is providing you with the opportunity to submit a detailed statement of explanation and any supporting documentation regarding the allegation.

If you do not provide a written statement within two weeks of receiving this letter, EMSA will proceed with the investigation without the benefit of your statement. If you have any questions or concerns regarding this matter, please feel free to contact me at (916) 322-4336, extension____.

Sincerely,

(Name of Investigator)
Enforcement Unit

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811-7043
(916) 322-4336 FAX (916) 445-0300



(Date)

(Name of Court)

Attn: Criminal Records

(Address)

Phone#:

Fax#:

RE: (Name of Respondent)

Case #:

Driver's License #:

DOB:

To Whom It May Concern:

Pursuant to the California Health and Safety Code, the Emergency Medical Services Authority (EMSA) is responsible for conducting background investigations on individuals who have applied for or currently have a paramedic license within the state of California.

California Health and Safety Code section [REDACTED] grants the EMSA the authority to conduct investigations into a paramedic's activities, this includes granting or denying a license based upon criminal activity. Moreover, according to Health and Safety Code Section [REDACTED] EMSA is authorized to receive criminal history information from both the Department of Justice and the Federal Bureau of Investigation as part of the licensure process. In addition, the California Penal Code Section [REDACTED] grants EMSA the authority to receive the above requested local criminal history information.

It has come to our attention that the above referenced individual may have a criminal conviction within your agency's jurisdiction. The above referenced individual is currently licensed as a paramedic in the State of California. Therefore, we are requesting a certified copy of the aforementioned conviction including any warrants ordered.

Your anticipated cooperation in this matter is greatly appreciated. If you should have any additional question or concerns, please do not hesitate to contact me at ([REDACTED]), extension ____.

Respectfully,

(Name of Investigator/Investigator Asst.)
Enforcement Unit

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811-7043
(916) 322-4336 FAX (916) 445-0300



(Date)

(Name of Law Enforcement Agency)

Attention: Records

(Address)

Phone#

FAX#

RE: (Name of Respondent)
Certified Copies of Police/Arrest Reports

Date of Incident: (Identify criminal violations)

DOB:

SSN#:

To Whom It May Concern:

Per the California Health and Safety Code, the Emergency Medical Services Authority (EMSA) is responsible for conducting background investigations on individuals who have applied for or currently have a paramedic license within the State of California.

California Health and Safety Code section [REDACTED] grants the EMSA the authority to conduct investigations into a paramedic's activities, this includes granting or denying a license based upon criminal activity. Moreover, according to Health and Safety Code Section [REDACTED], EMSA is authorized to receive criminal history information from both the Department of Justice and the Federal Bureau of Investigation as part of the licensure process. In addition, the California Penal Code Section [REDACTED] grants EMSA the authority to receive the above requested local criminal history information.

The above referenced individual is currently seeking licensure as a paramedic in the State of California. Therefore, we are requesting **certified copies of any and all police/arrest** reports that your agency may have for the above referenced individual.

Your anticipated cooperation in this matter is greatly appreciated. If you should have any additional question or concerns, please do not hesitate to contact me at [REDACTED]

Respectfully,

(Name of Investigator/Investigator Asst.)
Enforcement Unit



Paramedic Release and Waiver

I, (Name of Paramedic), hereby authorize any Emergency Medical Services Authority (EMSA) employee bearing this release or a copy thereof to obtain information contained in any file, computer bank, or other compilation system relating to pre-employment, offers of conditional employment, background investigations or actual employment, with the **(Name of Employer)**. This waiver shall relate to any and all information that refers or relates to applications, employment forms, reference checks, evaluations, documented discipline, written submissions, and termination or probation documentation compiled in my personnel or other pertinent file including any disciplinary and/or remediation files or records.

I hereby direct you to release this information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the Emergency Medical Services Authority.

Consent is granted for the Emergency Medical Services Authority to furnish the information described above to third parties in the course of fulfilling its official responsibilities.

I hereby release you, as the custodian of such records, and [REDACTED], including its officers and employees, both individually and collectively, from any and all liabilities for damage of whatever kind, which may at any time result to me, my heirs, family and associates resulting from the authorized release of information or attempted release of such information, pursuant to the terms of this release and waiver.

This release and waiver is valid for one year from date signed.

Signed this _____ day of _____ in the year _____.

Signed

Print Name

**ADMONISHMENT OF RIGHTS UNDER THE FIREFIGHTERS PROCEDURAL BILL
OF RIGHTS ACT**

The State of California Emergency Medical Services Authority (EMSA) is conducting an investigation into matters that may result in disciplinary action against your EMT-P license pursuant to California Health and Safety Code Section 1798.200 and the California Code of Regulations. As a person covered or potentially covered under the Firefighters Procedural Bill of Rights Act (California Government Code Section 3250 et. seq.), EMSA is informing you of certain rights you have pertaining to this investigation interview.

You have the right to:

1. Have this investigation interview conducted at a reasonable hour, during your normal duty time.
2. Be informed of the name and job classification of the EMSA employee conducting the investigation interview.
3. Be informed of the nature of the investigation.
4. Have the investigation interview conducted for a reasonable period of time. Reasonable breaks to attend to your personal physical necessities will be allowed.
5. An investigation interview free from offensive language. There are no rewards for answering questions, nor punishments for refusing to answer questions. EMSA requests that you answer any questions that you choose to respond to completely, honestly, and accurately to the best of your recollection.
6. Record this investigation interview with your own recording device if you choose. This investigation interview may be recorded by EMSA personnel. If it is recorded by EMSA personnel, you have the right to request and obtain a complete copy of the recording.
7. Obtain a copy of any complaints or reports associated with this investigation, subject to any laws pertaining to confidentiality of such documents.
8. Have a representative of your choosing present during the entire investigation interview, however this person cannot be a subject of this same investigation.
9. Give your express consent prior to searching any personal locker or storage space under your exclusive control. You have the right to refuse to provide consent if you choose.

I acknowledge that I have received a copy of this document prior to commencement of this investigation interview.

Date

Signature

EMERGENCY MEDICAL SERVICES AUTHORITY1930 9th STREET

SACRAMENTO, CA 95811-7043

(916) 322-4336 FAX (916) 322-8765



(Date)

(Name of Respondent)

(Address)

RE: CSAM Presettlement, Case No.

Dear Mr. /Ms. (Name of Respondent):

Pursuant to Section [REDACTED] the Emergency Medical Services Authority (EMSA) is authorized to revoke any EMT-P license issued under this division, upon a finding by the director of the occurrence of the following:

“Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel...” and

“Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.”

Your license is subject to discipline due to your (cite convictions).

Although your license is currently subject to discipline and an Accusation against your license will be issued shortly, EMSA may consider entering into a stipulated settlement agreement without adjudication once you complete certain requirements. Prior to entering into settlement discussions, EMSA requires that you undergo an evaluation by a physician certified in addiction medicine by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology (ABPN). The purpose of the evaluation is to determine whether you have an alcohol/or substance abuse disorder, which may pose a threat to the public health and safety in the prehospital emergency care environment. Please note that the evaluation will be completed at your expense. You can find a list of potential providers at www.csam-asam.org.

You must also complete the enclosed “Medical/Psychiatric Assessment Questionnaire,” as part of the evaluation process. You must complete this form truthfully and submit it to the physician who will be conducting the evaluation. Your physician will keep the form and review the answers with you. EMSA will not be receiving a copy of your completed form.

(Name of Respondent)

(Date)

Page 2

If you wish to participate in the fitness for duty evaluation, you must notify Investigator (name) within **seven (7) days of receipt of this letter**. Please provide Investigator (name) with the name of your chosen physician, the business address, and telephone number, so that EMSA can send pertinent correspondence to the physician. If you choose not to participate in the evaluation **or if you fail to respond to this letter within thirty (30) days**, your case will be forwarded to EMSA's Legal Office for the scheduling of an appeal hearing before an Administrative Law Judge.

Upon completion of the evaluation, EMSA will determine if settlement is warranted in this matter based upon the findings in the evaluation. If you do not agree that EMSA should receive your completed evaluation, then EMSA will not entertain settlement discussions; and you must file a Notice of Defense that will be provided to you along with the Accusation to preserve your right to an administrative hearing.

If you have any questions regarding this matter, please contact me at [REDACTED], extension____.

Sincerely,

(Name of Investigator)
Enforcement Unit

Enclosure

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95814-7043
(916) 322-4336 FAX (916) 322-8765



(Date)

(Name of Respondent)
(Address)

RE: CSAM Presettlement, Case No.

Dear Mr./Ms. (Name of Respondent):

The Emergency Medical Services Authority (EMSA) is denying your application for an unrestricted paramedic license pursuant to the licensing provisions of the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act ("Act")¹ and Title 22 of the California Code of Regulations.²

[REDACTED] of the California Health and Safety Code allows the Authority to deny any EMT-P license issued under this division, upon a finding by the director of the occurrence of "addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances." Your application for an unconditional license is being denied for the following reasons:

(SPECIFIC REASONS WHY APPLICANT IS DISQUALIFIED)

Although your application for an unconditional paramedic license has been denied, EMSA may consider issuing you a provisional license once you complete certain requirements. A provisional license will allow you to work as a paramedic under certain terms and conditions. The provisional license may become an unrestricted license provided you complete all the requirements set forth by the Authority. In determining your suitability for a provisional license, EMSA requires you to undergo an evaluation by a physician certified in addiction medicine by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology (ABPN), at your expense. You can find a list of potential providers by searching www.csam-asam.org. This evaluation must demonstrate to EMSA that you are not currently impaired or addicted by reasons of alcohol or substance abuse, and that you do not pose a threat to public health and safety when working in the prehospital environment.

Also enclosed is a "Medical/Psychiatric Assessment Questionnaire", which you must fill out honestly and completely and take with you to your evaluation appointment with a doctor of your choosing. Your doctor will review your answers with you during your evaluation. This document will be kept by your evaluator and will not be returned to the Authority. Payment for your evaluation must be arranged at your own expense. Within seven business days of your scheduled evaluation appointment, you must contact EMSA Investigator (Name of

¹ The Act is codified at Health and Safety Code, Division 2.5, [REDACTED].

² Further section references are to the California Health and Safety Code and references to regulation are to Title 22 of the California Code of Regulations.

Applicant Name

Date

Page 2

Investigator) with the name and address of your selected doctor. The investigator will provide the doctor with the evaluation information for your appointment.

If you do not agree with the potential issuance of a provisional license, and wish to contest the Authority's denial of your application for an unconditional EMT-P license, you must advise me in writing within the next thirty (30) days of your desire to contest the Authority's decision. Upon receipt of such a request I will proceed to issue you a "Statement of Issues" and a "Notice of Hearing" to have the matter heard before an Administrative Law Judge.

Please contact (Name of Investigator) if you have any questions regarding this letter or the evaluation at [REDACTED] extension ____.

Sincerely,

(Name of Investigator)

Enforcement Unit

Enclosure

Licensee Name

Date

Page 2

In order to assist in your evaluation of the paramedic or paramedic applicant, the Authority has provided the relevant case history. Please review this history prior to the paramedic or paramedic applicant's scheduled evaluation appointment. In order to assist you in your evaluation report, an outline entitled "Recommendations, Contents of the evaluation report" has been enclosed. The Authority asks that you use this as a guide when conducting and completing the paramedic or paramedic applicant's fitness for duty evaluation. Unless otherwise requested by the Authority Investigator, please follow Section 1 of the outline. Please complete a detailed report of this evaluation and provide to the Authority within 45 business days from the scheduled appointment. This report is reviewed in order to determine the paramedic or paramedic applicant's suitability for licensure. The Authority recognizes this is a wide assortment of information to provide, however, this information is imperative and time sensitive. Therefore, we request that you fax (916) _____, or mail a copy of the completed evaluation to the EMS Authority attention to: **(Name of Investigator)**.

The above referenced individual has also been asked to complete an extensive questionnaire that details their mental health, substance use, physical health, employment history, family and inter-personal relationships, recreation, financial, education and legal life. The individual is to provide the completed questionnaire to you at the start of your evaluation. You may keep the questionnaire filled out by the individual in his or her medical record file; due to privacy considerations please do not return it to the Authority.

Should you have any questions or concerns, please contact **(Name of Investigator)** at (916) _____ extension _____. Thank you in advance for your assistance in this matter.

Sincerely,

(Name of Investigator)
Enforcement Unit

Attachments:

Recommendations, Contents of the evaluation report, Relevant Case History Information



CSAM recommendations for the contents of evaluation reports and for the qualifications of physicians who conduct addiction medicine evaluations of health care professionals

Preamble

CSAM recognizes that health care personnel constitute a special population vis-a-vis licensing and privileging issues related to personal health and questions of substance abuse. At stake are the protection of the public and the public trust as well as the protection of the health and career of the physician or other health care provider.

Addiction medicine evaluations provide the information on which decisions about health, appropriate treatment and monitoring requirements, licensing and privileging are made. Such evaluations should address all the issues at stake in a coordinated way to meet the needs of the various parties--the person being evaluated, the licensing agency, those guiding treatment, those responsible for licensing and privileging, and perhaps others. Those who conduct such evaluations should have specific qualifications and the evaluation itself should be sufficient to support the necessary decisions.

For these recommendations, the CSAM Committee on the Well-being of Physicians first collected information from three licensing agencies in California showing what information they currently requested in evaluations. Committee members then prepared one document that identifies the core content they recommend as necessary to support decisions made to protect the public, to safeguard the personal and professional health of the person being evaluated, and to give sufficient support for decisions about treatment, monitoring, continuation of or return to practice.

Among the documents the Committee took into consideration were the action of the MBC/CSAM/CMA Liaison Committee to Diversion in 2000 identifying elements that should be included in the report to Diversion of a medical/psychiatric evaluation or an applicant or participant in the MBC Diversion Program and the June 2004 Physician Health Program Guidelines from the Federation of State Physician Health Programs.

These recommendations are based on the consensus of the members of the Committee. The Committee includes physicians who are members and chairpersons of hospital medical staff committees on physician health, members and chairpersons of the (now disbanded) Liaison Committee to the MBC Diversion Program for Physicians, members of the MBC Diversion Evaluation Committees, and members and chairpersons of county and state medical association committees on physician health, and examiners for the FAA.

RECOMMENDATIONS

Contents of the evaluation report

CSAM recommends that when addiction medicine evaluations of health care professionals are conducted for issues related to licensing or privileging or to any aspect of Diversion Programs, the evaluator's report should include at least these elements.

CSAM recommends that the ten elements listed in Section 1 of the table below should be addressed in the report of a basic substance abuse evaluation of a health care professional. The elements listed in Section 2 should be included in an extended or additional evaluation, or an expansion of the basic evaluation, if indicated.

<p>Section 1 <i>These elements should be included in the report of a basic substance abuse evaluation of a health care professional</i></p>	<p>Section 2 <i>These elements should be included in the report of an extended or additional evaluation if one is indicated</i></p>
<p>1) List of all sources of information the evaluator used, including</p>	<p>What interviews with family members, significant others, or others were conducted (with dates for those interviews)</p>
<p>-How many times did the evaluator meet with the person; the dates of those meetings</p>	<p>for the purpose of</p> <ul style="list-style-type: none"> -confirming the information with collateral sources -learning the concerns of family members
<p>- How much time did the evaluator spend in face-to-face interviews with the person</p>	
<p>-The evaluator's opinion on whether there are discrepancies between the information provided by the licensing agency or diversion program and the information provided by the person</p>	
<p>2) General medical history, including</p>	
<p>- family history</p>	
<p>- a review of all medications</p>	<p>More detailed history of pain (acute and chronic)</p>
<p>- drug/ alcohol history</p>	
<p>- history of other addictive behaviors</p>	
<p>3) General psychiatric history (e.g., under psychiatric care? Taking medications? Ever hospitalized?) Note: Unless there is a request for, or an indicated need for, a complete psychiatric evaluation, a general psychiatric history</p>	<p>Extended psychiatric exam by a qualified psychiatrist</p>

<p align="center">Section 1</p> <p align="center"><i>These elements should be included in the report of a basic substance abuse evaluation of a health care professional</i></p>	<p align="center">Section 2</p> <p align="center"><i>These elements should be included in the report of an extended or additional evaluation, if one is indicated.</i></p>
<p>performed by a non-psychiatrist is sufficient. If a complete psychiatric evaluation is indicated, it should be made by a qualified psychiatrist.</p>	
<p>4) Findings from a focused physical examination, as indicated</p>	
<p>5) Diagnosis (which may include DSMIV terminology) with the specific information supporting that diagnosis</p>	<p>Assessment of the person's insight into his/her problems; does the person accept the diagnosis</p>
	<p>Assessment of the person's readiness for change, or amenability to treatment</p>
	<p>Description of the evaluator's sense of what will be relapse risk factors for this person</p>
	<p>Description of the evaluator's sense of what will be positive support factors or systems for this person</p>
<p>6) Summary and concluding formulation</p>	
<p>7) Recommendations</p> <p>-Is treatment indicated?</p> <p>-The evaluator's determination of whether psychological testing is indicated</p>	<p>If treatment is indicated, include</p> <ul style="list-style-type: none"> -What are the treatment goals -What kind(s) of treatment are indicated -Treatment for alcoholism/ dependence -Medication - Psychotherapy / counseling -Other
<p>8) Response to each question posed by the requesting organization</p>	<ul style="list-style-type: none"> -For each kind of treatment, what level of intensity is indicated at this time - What measures will tell the diversion program or licensing agency personnel whether the person is making progress toward the goals of treatment
<p>9) Is continuing monitoring or further assessment or evaluation indicated to address the initiating concern? If so, specify what monitoring elements and give a recommended schedule.</p>	<p>What monitoring elements are needed to gather the information that will allow the diversion program or licensing agency personnel to decide if the person is making progress toward the goals of treatment</p>
<p>10) Are other steps indicated? If yes, specify</p>	<p>What monitoring elements are needed to allow the diversion program or the licensing agency to decide if the person is safe to return to or continue work</p>

Information to be provided in advance to the evaluator

CSAM recommends that the organization requesting an evaluation should provide the following information, in advance, to the evaluator. (The information provided should be made a part of the evaluator's report, by inclusion or attachment.)

- 1) List of the person's current duties, roles and functions
- 2) The circumstances leading to the request for the evaluation
 - b) Is there a particular drug identified in the concern
 - c) Is there a particular behavior identified in the concern
 - d) Is the person currently under investigation
 - e) Is the person currently charged with an offense
- 3) Prior circumstances /history / observed behavior/expressed concerns
- 4) Recent or current treatment
- 5) What will the report's information and recommendations be used for?
What is the reason for requesting the evaluation?
- 6) Are there specifics that the requesting program wants to have included or described in the report?
 - a) a diagnosis
 - b) the person's view of his/her diagnosis: does the person accept the diagnosis
 - c) the person's readiness for change
 - d) if others, list them
- 7) If there are questions on which the program wants *recommendations*, specify the questions.

Qualifications of physicians who conduct evaluations

CSAM recommends the following qualifications for physicians who conduct addiction medicine evaluations of health care professionals when the evaluations are conducted for issues related to licensing, privileging or any aspect of Diversion Programs.

Qualified physician evaluators meet seven criteria. The seventh is the demonstrated ability to provide reports on time, with sufficient and appropriate information to support peer review action. Whether a physician meets this criterion can be determined only by the licensing agency or diversion program which requests the evaluations and only after a physician has submitted the at least one evaluation report.

- 1) Certification by ASAM in Addiction Medicine or Certification by ABPN in Addiction Psychiatry

NOTE: Some physicians who are not certified in Addiction Medicine or Addiction Psychiatry may be considered qualified if they meet all the other criteria and are deemed qualified by (or "grandfathered" by) the agency or program requesting the evaluation.

- 2) A minimum of 14 hours of Category 1 continuing medical education in

addiction medicine or addiction psychiatry every two years

- 3) Experience-This criterion may be met in anyone of the following ways:
 - a) at least two years' experience in peer review activities in an organized health care setting, or
 - b) in a hospital medical staff, a diversion program or other organized health care setting, experience of having done at least two substance abuse assessments of health care professionals and submitted the reports, including recommendations for treatment and monitoring, or
 - c) participation in an workshop (minimum of 6 hours) focused on the clinical and administrative essentials of how to conduct and report substance abuse evaluations in health care professionals
- 4) No conflict of interest that would prevent unbiased recommendations
- 5) A current, unrestricted medical license in good standing; no current accusation pending and no complaints "closed with merit"
- 6) Not a current participant in the Diversion Program; if a successful graduate of the Diversion Program, the physician must have completed the Diversion Program by at least one year or the same number of years as is required by the MBC for selection of expert reviewers or DEC members.
- 7) Ability to provide reports on time, with sufficient and appropriate information to support peer review action. The reports should contain at least the elements recommended by CSAM.

Note: This criterion can be judged only by the licensing agency or diversion program which requests the evaluations and only after a physician has submitted the at least one evaluation report.

GBJ

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Relevant Case History Information

(When filing out this form, please only include information that is public information.)

(Respondent Name, P*****)

EMSA Case:

Investigator:

Arrest

On (Date of the Arrest), (Respondent) was arrested for a violation of (Insert VC), by the (Arresting Agency) (Respondent's) blood alcohol level at the time of this arrest was _____% as stated on the police report.

Conviction

On (Date of Plea), (Respondent) pled _____ to a misdemeanor violation of (Insert Code). The (Respondent) was sentenced as follows: (sentencing information)

(Respondent) (has or has not) successfully completed the (Insert the DUI program i.e., 3 month, 1st Offender Program, MADD)

MEDICAL / PSYCHIATRIC ASSESSMENT QUESTIONNAIRE

Please complete this questionnaire and bring it with you to your initial appointment

Date: _____

A. Please tell us about yourself.

Name

Home Address: Street City State Zip Code

Check box if home is preferred mailing address.

Work Address: Street City State Zip Code

Check box if work is preferred mailing address.

Other Address: Street City State Zip Code

Check box if other is preferred mailing address.

Telephone Cell Phone Email

Age Gender Marital Status

Paramedic License # Date Issued

Ethnic Origin (i.e. White, Hispanic, Black, Asian)[Optional]

Current Living Situation (i.e. Rent/Own, house, apartment, members of your household)

B. Presenting Problem: (A summary of the circumstances which resulted in you being ordered to undergo this medical/psychiatric evaluation)

C. Please describe any prior participation in an assessment or treatment for problems with drugs and/alcohol.

I. Mental Health

A. Please tell us about your mental health history, if applicable (depression, anxiety, chemical dependency, bipolar disorder, schizophrenia, suicide attempts, etc.)

1. _____
Problem/Diagnosis _____ Dates _____

Type of Program/Treatment _____ Medication _____

Was it helpful? _____

2. _____
Problem/Diagnosis _____ Dates _____

Type of Program/Treatment _____ Medication _____

Was it helpful? _____

3. _____
Problem/Diagnosis _____ Dates _____

Type of Program/Treatment _____ Medication _____

Was it helpful? _____

B. Please tell us if you have ever experienced any of the following and indicate dates and duration, e.g., last 6 months, 5 years ago:

<u>Conditions/Symptoms</u>	<u>Dates/Duration</u>
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Anxiety, excessive worry	_____

- Suicidal ideation / behavior _____
- Homicidal ideation / behavior _____
- Abuse of any kind _____
- Difficulty concentrating _____
- Fights _____
- Compulsive behavior
(eating, sex, work, substances) _____
- Shopping sprees _____
- Phobia _____
- Mania _____
- Feelings of worthlessness _____
- Hallucinations _____
- Feelings of intense shame or guilt _____

C. Please tell us if you have experienced problems in any of the following areas. Please note the approximate date and give a brief description.

- Gambling
- Sexual compulsion / Addiction
- Eating Disorders
- Relationships
- Internet Addiction
- Other

D. Please describe any negative consequences you have experienced as a result of adverse mental health in any of the following areas:

- Relationships

- Career

- Financial

- Health (include emotional health)

- Legal

- Personal

- Sexual

II. Substance Use

A. Please tell us about your history with substance use, if applicable.

1. _____

Substance Used	Method of Use (e.g. oral, inject, etc.)	Date of first Use

2. _____

Substance Used	Method of Use (e.g. oral, inject, etc.)	Date of first Use

3. _____

Substance Used	Method of Use (e.g. oral, inject, etc.)	Date of first Use

Last Use Frequency Reason for Stopping

4.

Substance Used Method of Use (e.g. oral, inject, etc.) Date of first Use

Last Use Frequency Reason for Stopping

5.

Substance Used Method of Use (e.g. oral, inject, etc.) Date of first Use

Last Use Frequency Reason for Stopping

B. Have you ever experienced any of the following?

- Shakes
- Blackouts
- Hallucinations
- Convulsions/Seizures

C. In general terms, please describe the way(s) you used substances, i.e., alone, with friends, social settings.

D. Please describe any negative consequences you have experienced as a result of substance abuse in the following areas:

- Relationships

- Career

- Financial (please include an estimate of the annual cost of substance abuse)

- Health (include emotional health)

- Legal

- Personal

- Sexual

E. Please describe any treatment you have undertaken for substance abuse.

1.	_____	_____
	Problem/Diagnosis	Dates
	_____	_____
	Type of Program/Treatment	Medications

	Was it Helpful?	
2.	_____	_____
	Problem/Diagnosis	Dates
	_____	_____
	Type of Program/Treatment	Medications

	Was it Helpful?	
3.	_____	_____
	Problem/Diagnosis	Dates
	_____	_____
	Type of Program/Treatment	Medications

	Was it Helpful?	

4.

Problem/Diagnosis	Dates
Type of Program/Treatment	Medications
Was it Helpful?	

F. Please describe any significant periods of sobriety/abstinence in the past 5 years and the means you used to achieve it.

G. Please list the date at which you began to think you had a problem with alcohol or drugs. What were the surrounding circumstances?

H. Please describe your involvement with "12 Step" or other abstinence-based self-help groups. Include dates.

III. Physical Health

A. Please tell us about your physical health.

- Please describe all serious illnesses, hospitalizations and surgeries. Include treatment and response to treatment.
- Please describe any current medical concerns.
- Please describe your level of exercise, past and present.
- Please describe your eating habits, including frequency and type of food.
- Please describe your past and present use of tobacco and caffeine.
- Who is your primary care physician (PCP) and when was your last contact? Does your PCP know about your current Substance Abuse / Mental Health condition?

B. What medications are you taking currently? Include any OTC medications, herbal remedies, health food preps, supplements, vitamins, etc.

1.	_____	_____	_____
	Medication	Source (e.g., Physician)	Date Last Filled
	Reason for taking it	Side Effects	Is it Helpful?
2.	_____	_____	_____
	Medication	Source (e.g., Physician)	Date Last Filled
	Reason for taking it	Side Effects	Is it Helpful?
3.	_____	_____	_____
	Medication	Source (e.g., Physician)	Date Last Filled
	Reason for taking it	Side Effects	Is it Helpful?

4.

Medication	Source (e.g., Physician)	Date Last Filled
Reason for taking it	Side Effects	Is it Helpful?

C. Describe any additional issues involving your physical health

IV. Employment History

A. Please tell us about your current paramedic employment.

Ambulance company _____ Public safety agency (police/fire) _____

Paid / Volunteer _____

Job Status (suspended, will be fired, medical leave, etc) _____

Number of hours worked per week: minimum _____ maximum _____

Co-worker knowledge of problems _____

Length of time in current job _____

B. Please tell us about your License Status (past/present license in other states, enforcement actions against you, restrictions, etc.)

C. Please tell us about your Future/Retirement Plans _____

D. Employment History:

1.

Employer _____ Dates _____

Duties _____

Reason for Leaving _____ Position Held _____

2.

Employer _____ Dates _____

Duties _____

Reason for Leaving _____ Position Held _____

3.

Employer _____ Dates _____

Duties _____

Reason for Leaving _____ Position Held _____

4.

Employer	Dates
Duties	
Reason for Leaving	Position Held

V. Family & Relationships

A. Please tell us about your family of origin.

- Please describe your parents. Include marital status, substance abuse/mental health history (if any), personalities, values, deaths, chronic illnesses, past and present quality of relationship, etc.
- What were the discipline patterns and parenting styles in your family?
- Please describe your siblings, if any. Include number, gender, birth order, substance abuse/mental health history (if any), personalities, deaths, past & present quality of relationship.
- Did you experience physical abuse, sexual abuse, or neglect in your family of origin?
- Which family members know of your substance abuse/mental health history and what is their opinion?
- Who is supportive of you and who is not?

B. Please tell us about your relationship history.

- Please describe your current relationship status, (i.e., married, single, widowed, divorced, separated, dating, living together).
- How would you describe the quality of your current relationship? (i.e., good, troubled, distant, supportive, violent, conflictual).
- Please indicate the number of times you have been married, and if divorced, the length of the marriage(s) and the reason for the marriage(s) ending.
- If substance abuse was involved in a relationship (i.e., your partner used), please describe the relationship and the effect of substance abuse on it.
- Do you have children? _____ Living at home? _____ Not at home? _____
Names and ages _____
- Please describe significant friendships and indicate if substance abuse is involved.
- Do you have any pets? Please describe.

College/University Attended

Dates

D. Please tell us about your legal history.

- Please describe any arrests as a juvenile or adult, including charges, dates and disposition.

- Please describe any impending legal concerns, including present status on probation, if applicable.

VII.

What are your expectations of this assessment and the current action in process on your paramedic license?

VIII.

Do you have any additional issues, concerns or questions regarding your physical or emotional health?

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95814-7043
(916) 322-4336 FAX (916) 322-8765



(Date)

(Name of Respondent)
(Address)

RE: State of California Paramedic Application

Dear Mr./Ms. (Name of Respondent):

As of (date), the Emergency Medical Services Authority (EMSA) denied your application for an unrestricted paramedic license. However, EMSA may consider issuing you a probationary license/agreement once you complete certain requirements. Based upon prior conversations and recent email correspondence with you, EMSA will agree to settle this matter based upon the results of a fitness for duty evaluation from a licensed doctor who is a member of the American Society of Addiction Medicine or the California Society of Addiction Medicine. As of this date, EMSA has not received a completed evaluation.

This letter is to inform you that unless EMSA receives the completed evaluation from your chosen physician on or before (date), the offer to potentially settle this matter without a hearing will be withdrawn and EMSA will uphold the (date) denial of your California paramedic license. If, after contemplation, you choose not to have a fitness for duty evaluation performed, please notify us of your decision immediately so that we may schedule the matter to be heard by the Office of Administrative Hearings.

Should you have any questions about this letter, please feel free to contact me at (916) 322-1999 extension ____.

Sincerely,

(Name of Investigator)
Enforcement Unit

[Name]

[Date]

Page 2

If EMSA does not receive any contact from you within thirty (30) days, you will be denied by default. If you have any questions regarding this letter please contact Investigator (name) at [REDACTED] extension___.

Sincerely,

(Name of Chief)

Chief of Enforcement

Emergency Medical Services Authority

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 958117043
(916) 322-4336 FAX (916) 322-8765



(Date)

(Name of Respondent)
(Address)

RE: EMSA Case No. _____, Paramedic License No. _____

Dear Mr./Ms. (Name of Respondent):

Pursuant to the California Health and Safety Codes (H&S), the Emergency Medical Services Authority (EMSA) is authorized to make inquiries into allegations of paramedic misconduct. EMSA has conducted an investigation into the allegation that on or about (date), you (state the allegation).

This letter informs you that EMSA has completed the investigation of the above allegation(s). EMSA has decided not to take any disciplinary action and will be closing this case. However, should future incidents occur which necessitate review by EMSA, all facts and evidence, both past and present, will be considered in reaching appropriate licensure action.

Thank you for your cooperation in this matter. If you have any questions or concerns, please feel free to contact me at (██████████) extension ____.

Sincerely,

(Name of Investigator)
Enforcement Unit.

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811 7043
(916) 322-4336 FAX (916) 322-8765



(Date)

(Name of Respondent)
(Address)

RE: EMSA Investigation Case No.

Dear Mr./Ms. (Name of Respondent):

Pursuant to the California Health and Safety Codes (H&S), the Emergency Medical Services Authority (EMSA) is authorized to make inquiries into allegations of paramedic misconduct. EMSA has conducted an investigation into the allegation that on or about (date), you (state allegation).

Based upon EMSA's investigation into the matter, EMSA has concluded that there is insufficient evidence to substantiate the allegation. Therefore, EMSA is closing this case file.

Thank you for your cooperation in this matter. If you have any questions or concerns, please feel free to contact me at (██████████) extension____.

Sincerely,

(Name of Investigator)
Enforcement Unit

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811-7043
(916) 322-4336 FAX (916) 445-0300



(Date)

(Name of LEMSA
Address)

RE: EMSA Case #
Name of Respondent, EMT-P #

Dear Mr./Ms. (Name of LEMSA contact):

This letter is to notify you that the Emergency Medical Services Authority (EMSA) has completed its investigation into a complaint we received regarding (Name of Respondent). EMSA is not taking any formal licensure action at this time. For your files, enclosed is a copy of the letter EMSA sent to (Name of Respondent).

If you have any questions regarding this matter, please call (Name of Investigator) at (██████████) ██████████, extension ____.

Sincerely,

(Name)
Chief Investigator

Enclosure

NO LONGER INTERESTED NOTIFICATION

BCII 8302 (rev. 3/05)

California Penal Code section 11105.2(d) states, in part, that any agency which submits the fingerprints of applicants for employment or approval to the Department of Justice for the purpose of establishing a record of the applicant to receive notification of subsequent arrests, shall immediately notify the department when employment is terminated or the applicant is not hired.

It is the responsibility of the hiring/approving authority to notify the Department of Justice, Bureau of Criminal Identification and Information when employment has been terminated or when an applicant or volunteer is not actually retained in the position for which they applied.

Reason for the NLI notification:

- Applicant not hired.
- Applicant 's employment was terminated.
- Applicant's license or certification was denied or revoked.
- Other - Explain: _____

Applicant Information (please print):

<i>(Last)</i>	<i>(First)</i>	<i>(Middle)</i>
* Name (Mandatory)		
Aliases (Maiden name, AKA's)		Sex
* Date of Birth (Mandatory)	Social Security Number	
* Application Type (Mandatory) [REDACTED]		
<i>(Specific to requesting agency i.e, credentialed, classified, volunteer, non-sworn, license, permit, peace officer, etc.)</i>		

Agency Information:

* Agency Name and Address (Mandatory) [REDACTED]	Agency ORI (if known) [REDACTED]
Contact Person	

* Form must be filled out completely to ensure timely processing.

Mail or FAX this notification to:

Department of Justice
Bureau of Criminal Identification and Information
 P.O. Box 903417
 Sacramento, CA 94203-4170
 FAX (916) 227-4722

Reset

EMSA CASE SUMMARY

Respondents Name _____ Case No. _____ License# _____

Violation of H&S 1798.200 (c) (6) Conviction of any crime which is substantially related to the qualifications, functions and duties of prehospital personnel.

Date Case Opened _____

Offense _____ Date _____

Conviction _____ Date _____

_____ Indicated on EMSA application that he/she has prior convictions

_____ Did not indicate prior convictions on EMSA application

Disclosed to Local EMS Agency Yes No (if no, please explain)

Disclosed convictions on prior EMSA applications (Renewals only) Yes No

DMV INFORMATION

_____ Driver Record Information Request sent to DMV Date sent _____
Date received _____

_____ DMV printout clean

_____ DMV printout confirms written statement

_____ Other

FINGERPRINT INFORMATION

_____ DOJ _____ No Criminal History _____ Confirms Written Statement

_____ Additional Arrests/Conviction

_____ FBI _____ No Criminal History _____ Confirms Written Statement

_____ Additional Arrests/Conviction

_____ Done through Initial Application process

RECOMMENDATION

No Action Taken Warning Letter

REASON

Length of time since conviction

Truthful to our agency and/or the LEMSA

No other criminal convictions

The crime convicted of, in and of itself, does not pose a threat to health and public safety

Lack of resources

No longer interested

Infraction

Juvenile conviction

Disciplinary Action is not warranted at this time.

Submitted by: _____

Date: _____

Approved By: _____

Date: _____

EMERGENCY MEDICAL SERVICES AUTHORITY1930 9th STREET

SACRAMENTO, CA 95811

(916) 322-4336 FAX (916) 324-2875



February 4, 2010

CERTIFIED MAIL

Name

Address

Re: EMSA Case

Dear Mr.:

Our records show that you are in violation of your probation. Failure to comply with the terms and conditions of your probation may result in further disciplinary action. We have not received the following item(s):

- Quarterly Reports – Reporting period _____
- Employer notification form
- Preliminary Alcohol Screening (PAS) testing
- Ethics course certificate
- Stress/anger management course certificate
- Substance abuse program
- AA attendance sheet

Please submit the requested information within ten days from the date of this letter. If the information is not received within this time frame, your file will be forwarded to our legal department for further action. If you have further questions, please don't hesitate to call me at [REDACTED] ext [REDACTED] or email at [REDACTED].

Respectfully,

[REDACTED]

EMERGENCY MEDICAL SERVICES AUTHORITY1930 9th STREET

SACRAMENTO, CA 95811

(916) 322-4336 FAX (916) 324-2875

**Functioning as a Paramedic Information Form****Name:****License:****Case #:**

I am in the process of updating your probationary file. Our records indicate that you are **not** currently practicing as a paramedic within the jurisdiction of California as stated in your Settlement Agreement under:

Functioning as a Paramedic: The period of probation shall not run anytime that Respondent is not practicing as a paramedic within the jurisdiction of California. If Respondent leaves the jurisdiction of California to practice as a paramedic, he must immediately notify the Authority, in writing of the date of his departure and the date of the return to California, if he returns to California, Respondent license will be subject to any remaining period of suspension and/or any and all terms and conditions of this probation which remain unsatisfied. Respondent will maintain an active license with the Authority. Should Respondent's license lapse or expire by operation of law or otherwise, upon renewal or reinstatement, the license will be subject to any and all terms and conditions of this probation which remain unsatisfied.

In order to ensure you are not in violation of your Settlement Agreement, please review the information below and check the appropriate box that applies to your paramedic status. This information can be returned to my attention via fax at [REDACTED], e-mail at [REDACTED] or a postal service of your choice.

I am not currently working as a paramedic

I am working as a paramedic *

Employer's Name*

Signature: _____

Date: _____

***Please note:** As per your Settlement Agreement, once you start working as paramedic you will need to provide me with a letter from your employer within 10 days, indicating your start date and that they have been given a copy of your Settlement Agreement.



EMERGENCY MEDICAL SERVICES AUTHORITY PROBATION UNIT



AA Attendance Form

Date	Name	Sponsor's Name	Sponsor's Phone #	Name & location of meeting	Signature

* Please make copies of this as needed.



**EMERGENCY MEDICAL SERVICES AUTHORITY
PROBATION UNIT**



MONTHLY PAS TESTING LOG
(Due by the 5th of each month)

Probationer's Name:

Date	Time	Reading/Results	Employer Name (Print)	Signature

I hereby certify under penalty of perjury that all information on this form is true and correct to the best of my knowledge and belief.

Signature of Employer: _____ **Date:** _____

* Please make copies of this as needed.

EMERGENCY MEDICAL SERVICES AUTHORITY1930 9th STREET

SACRAMENTO, CA 95811

(916) 322-4336 FAX (916) 324-2875

**Name:****Probationary Terms and Conditions
(required terms are highlighted)****Terms are checked off once completed****Working: Y N**

- Function as a Paramedic**
- Quarterly Reports**
- Employer Notification Form**
- Employer Evaluation**
- Notification of Termination**
- Ethics Course Certificate**
- Stress/Anger Management Course Certificate**
- Fingerprint DOJ**
- Substance Abuse Program**
- AA Attendance Sheet**
- Education Course Work**
- Obey all Laws**
- Biological Fluid Testing**
- Psychiatric/Medical Evaluation**
- Other _____**

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811
(916) 322-4336 FAX (916) 324-2875



Employment Notification

One of the conditions of your probation requires you to notify the EMS Authority of your EMS employer(s) or prospective EMS employer(s) of your probationary status and provide them with a copy of your Agreement. (If you have more then one employer, please make copies as needed). Please complete the information and return it to your Probation Monitor within 10 days.

I certify that a copy of my Agreement was giving to my EMS employer or prospective employer and they are fully aware that my paramedic license has been place on probation.

Probationer (print name)

Signature

Date

This section is to be completed by Employer

I have received a copy of the Agreement from the probationer listed above and I'm aware of their probationary status.

Employer name (print name)

Signature

Date

Employer's Name and Address:

Telephone: _____



**Emergency Medical Services Authority
Paramedic Enforcement Unit
1930 9th Street
Sacramento, CA 95811
Quarterly Declaration**



1. Quarterly Reporting Period:				
<input type="checkbox"/> 1/1 to 3/31 Due Apr 15th	<input type="checkbox"/> 4/1 to 6/30 Due Jul 15th	<input type="checkbox"/> 7/1 to 9/30 Due Oct 15th	<input type="checkbox"/> 10/1 to 12/31 Due Jan 15th	
2. Personal Information to be completed each quarter				
Paramedic License No. _____				
Name _____			Cell Phone: _____	
Residence Address _____				
City/State/Zip Code: _____				
Change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail Address _____				
3. Employment information to be completed each quarter				
1 st Employer Name: _____		Telephone _____		
Address _____				
City/State/Zip Code _____				
2 nd Employer Name _____		Telephone _____		
Address _____				
City/State/Zip Code _____				
4. Attach verification/reports for any of the following that apply to you:				
<input type="checkbox"/> Coursework/CE	<input type="checkbox"/> Ethics Course	<input type="checkbox"/> Stress/Anger Mgmt.	<input type="checkbox"/> Medical Treatment	
<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> AA Attendance	<input type="checkbox"/> Drug Detox/Diversion	<input type="checkbox"/> Other _____	
5. Since the last Quarterly Declaration have you been arrested, charged, or convicted of any Federal or State offense, or any county or city laws, rules or regulations? (Exclude parking tickets)				
<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" explain answer on a separate sheet of paper and attach to this form)				
6. During this reporting period have you complied with each and every term and condition of probation?				
<input type="checkbox"/> Yes <input type="checkbox"/> No (If "No" explain answer on a separate sheet of paper and attach to this form)				
7 If you did not practice all or part of the period covered by this report, include date you ceased practice				
_____ and date you resumed practice _____				

Executed on _____, at _____, _____ California.				
(Date)		(City)		(County)
By signing here, I acknowledge that the above is true and correct.				
_____ Probationer Signature				

Mail this form to EMSA at the above-listed address.)
Probationer: Retain a copy of this form for your records

(Revised 03/2010)