STATEMENT OF COMPLAINT

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

Harrisburg

In order for the Department of State to initiate an investigation of possible violations of the licensing, registration, certification or notary commission laws and regulations of the Commonwealth by a licensee, registrant, certificate holder or notary commission holder of the Department, the complainant must complete and sign this form. Failure to supply complete and accurate information may result in delayed processing of your complaint. Please be aware that pursuant to Act 25 of 2009, 63 P.S. §2205.1, if you submit a complaint anonymously, the Department will not be able to share any information pertaining to the complaint with anyone, including you. Please return this completed form to: **DEPARTMENT OF STATE, PROFESSIONAL COMPLIANCE OFFICE, 2601 NORTH THIRD STREET, P.O. BOX 69522, HARRISBURG, PA 17106-9522.**

TYPE OF COMPLAINT: ☒ PROFESSIONAL/OCCUPATIONAL LICENSE/CERTIFICATE/REGISTRATION ☐ NOTARY ☐ OTHER

A. COMPLAINANT INFORMATION

LAST NAME	FIRST	MIDDLE INITIAL
McNamara	Robert	M

STREET ADDRESS (Number and Name): 830 Foxwood Circle

CITY	COUNTY	STATE	ZIP CODE
Lafayette Hill	Montco	PA	19444

TEL. (Include Area Code) (HOME)	(WORK)
215-370-9033	

B. COMPLAINANT'S ATTORNEY, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL

STREET ADDRESS (Number and Name):

CITY	COUNTY	STATE	ZIP CODE

TEL. (Include Area Code)	FIRM NAME

C. NAME AND ADDRESS OF WITNESS, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL

STREET ADDRESS (Number and Name):

CITY	COUNTY	STATE	ZIP CODE

TEL. (Include Area Code)	If needed, is this witness willing to support your complaint by appearing at a hearing? ☐ YES ☐ NO

D. NAME AND ADDRESS OF SECOND WITNESS, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL

STREET ADDRESS (Number and Name):

CITY	COUNTY	STATE	ZIP CODE

TEL. (Include Area Code)	If needed, is this witness willing to support your complaint by appearing at a hearing? ☐ YES ☐ NO

NOTE: If additional witnesses are available, list names, addresses, and other pertinent data in a manner similar to above on 8½ x 11" paper.

E. ARE YOU WILLING TO APPEAR AT A HEARING IN HARRISBURG IF NECESSARY? ☒ **YES** ☐ **NO**

DEFENDANT INFORMATION

F. BUSINESS ESTABLISHMENT INVOLVED, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL
Emergency Care Services of Pennsylvania, PC		

STREET ADDRESS (Number and Name): 307 South Evergreen Avenue

CITY	COUNTY	STATE	ZIP CODE
Woodbury		NJ	

TEL. (Include Area Code)	PROPRIETOR

G. INDIVIDUAL INVOLVED, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL

STREET ADDRESS (Number and Name):

CITY	COUNTY	STATE	ZIP CODE

TEL. (Include Area Code)	LICENSE/REGISTRATION/ CERTIFICATE/COMMISSION TYPE AND NUMBER IF KNOWN

H. THIS SECTION IS FOR NOTARY COMPLAINTS ONLY:

Expiration date of notary's commission if known *(this date should appear on the notary's stamp, printed beneath the notary seal)*:	Date of transaction for which this complaint is being filed:
_____	_____

I. DESCRIPTION OF COMPLAINT

Please describe your complaint in detail below. State the facts briefly and clearly. List services provided by the licensee, registrant, certificate holder or commission holder. Provide relevant dates. List fees paid for notary services, if applicable. Attach **copies** of related documents that support your complaint. Do **NOT** enclose original documents, as they cannot be returned to you. If you need more space to describe your complaint, please continue on additional 8½ x 11" sheet(s) of paper.

Complaints should be typewritten or clearly printed in black or blue ink.
Please keep a copy of your Statement of Complaint form for your records.

Emergency Care Services of Pennsylvania, PC has sent contracts for signature to emergency medicine physicians currently employed by Crozer Keystone Health System. This PC is believed to be wholly owned and controlled by a lay entity known as TeamHealth an emergency department staffing company owned by the Blackstone Group. The PC is believed to be a shell that has been established to avoid scrutiny under the current PA prohibitions on the corporate practice of medicine. Indeed, the letterhead of the contract is TeamHealth a lay entity. The PA Bureau of Professional and Occupational Affairs has a number of times issued statements prohibiting lay control over the practice of medicine. (Memo from Mary Shehadi to Wayne Dietrich, 7/3/79; Letter from Cynthia Williams to John Weiner, 4/9/94; letter from John Henderson to Melinda J Roberts, 5/3/94). It is the concern of the complainant that a lay entity will be practicing medicine in PA.

Team Health will hire and fire physicians, determine physician staffing levels, decide on which type of provider sees the patient in the Crozer emergency departments, perform quality and peer review activities on the physician practice and control the financial aspects of the physician practice. As stated before by the Bureau it is contrary to the public interest for physicians to have a divided loyalty between their business employer and their patients.

It is the belief of the complainant that, upon investigation, Emergency Care Services of Pennsylvania, PC will be shown to be a shell constructed to allow TeamHealth to practice medicine in the state of PA. It is believed that the contract for emergency services at the Crozer Keystone Health System as evidenced in the contractual agreements will indicate that it is TeamHealth and not the PC that is controlling the physician practice.

J. RESOLUTION

How would you like this complaint to be resolved?

After examination of the arrangement it is believed that the emergency physicians should remained employed by Crozer Keystone Health System or an alternative contracting entity that is not prohibited under the corporate practice of medicine prohibitions becomes the vehicle for physician staffing in the Crozer system's emergency departments.

K. COMPLAINANT'S VERIFICATION

I verify that the facts and statements set forth in this complaint are true and correct to the best of my knowledge, information and belief. I understand that statements in this complaint are made subject to the criminal penalties of 18 Pa.C.S. §4904 relating to unsworn falsification to authorities.

x _____
(FIRST COMPLAINANT'S SIGNATURE)

DATE: _____

x _____
(SECOND COMPLAINANT'S SIGNATURE, IF ANY)

DATE: _____

x _____
(SIGNATURE OF PERSON COMPLETING THIS FORM, IF OTHER THAN COMPLAINANT)

DATE: _____

SUBMIT COMPLETED FORM BY MAIL TO: **Professional Compliance Office**
Department of State
2601 North Third Street, P.O. Box 69522
Harrisburg, PA 17106-9522
OR BY: **Fax 717-705-2882**

L. RECORDS RELEASE *(PLEASE COMPLETE IF IT APPLIES TO YOUR COMPLAINT)***.**

TO WHOM IT MAY CONCERN:

THIS WILL AUTHORIZE N/A
(Name of physician, practitioner, hospital or clinic)
to release to the Department of State and its authorized representatives any pertinent medical records and copies of x-rays relating to

_____
(Patient's name)
for the purpose of investigating a complaint.

_____ Signature	_____ Witness
Date:	Date:

THANK YOU FOR BRINGING YOUR CONCERNS TO OUR ATTENTION.