COMPLAINT FORM

Type directly into this form OR print the form and fill it out in **ink**. All complaints **must** be signed. Return to:

Maryland Board of Nursing
Complaints & Investigations Division
4140 Patterson Avenue
Baltimore, MD 21215-2254
410-585-1925 or 1-888-202-9861
Fax: 410-358-3530

FOR OFFICE USE ONLY:

RECEIVED BY BOARD _____/_____/_____

REFERRED TO REHAB _____/_____/_____

RECEIVED BY CID _____/_____/_____

CURRENT NIS# _____

PREVIOUS NIS# _____

1. Who is the person you are complaint against?

☐ Advanced Practice Registered Nurse (APRN, i.e., CRNA, CNM, ARNP, CNS)

☐ Registered Nurse (RN)

☐ Licensed Practical Nurse (LPN)

☐ Electrologist

☐ Certified Nursing Assistant (CNA, i.e., GNAs, CMAs, Home Health or School Aide, and Dialysis Techs)

☐ Medication Technician

☐ Medicine Aide

☐ Other (i.e. misrepresentation, imposter, etc.)

2. What is the name of the person who you are complaining against?
Provide any information you have.

Full Name: _____
First Middle Last Title

Home Address: _____

City: _____ State:____ Zip code: _____

Home Phone: (_____) _____ - _____

Place of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip code: _____

Work Phone: (_____) _____ - _____

Name of Agency (if applicable):_____ Phone#:_____

Date of Birth: _____/_____/_____ Cert/License No.: _____

3. Who are you?

Your Name: _____
First Middle Last

Your Title: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Employers Only: Name of your agency or facility: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Employer's Fax Number:_____

Was the employee terminated? ☐YES ☐NO

If yes, what was the date of termination:_____

4. What is your relationship to the licensee or certificate holder?

Patient	☐YES	☐NO
Relative of a Patient	☐YES	☐NO
Supervisor/Administrator	☐YES	☐NO
Co-Worker	☐YES	☐NO
Physician	☐YES	☐NO
Other regulatory agency	☐YES	☐NO
Law Enforcement	☐YES	☐NO
Member of the public	☐YES	☐NO

5. Does the licensee/certificate holder know you are making this complaint?

☒ YES ☒NO

If no, state reason _____

_____

6. **When did this incident happen?**
Provide as much detail as you can. Use additional sheets of paper if needed.

Date: Place:

_____/ _____/_____ _____

_____/_____/_____ _____

7. **Who witnessed the incident you are complaining about?**
Provide name, address and telephone number of any witnesses, including physicians, co-workers or other employees:

Name Address Phone

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

8. Have you made this complaint to any other person or organization? ☐YES ☐NO

If yes, to whom_____

9. What is your complaint?
Provide as much detail as necessary. *Use as many additional pages as necessary, number and sign each additional page at the end of each page.*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. What is the evidence of your complaint?

Do not redact or black out any names or information.

Witness statements	☐YES ☐NO ☐N/A
Medical records including physician orders	☐YES ☐NO ☐N/A
Medication administration records	☐YES ☐NO ☐N/A
Nursing and physician/provider progress notes	☐YES ☐NO ☐N/A
Nursing flow sheets	☐YES ☐NO ☐N/A
Controlled substance logs	☐YES ☐NO ☐N/A
Employee personnel records	☐YES ☐NO ☐N/A
Facility policies	☐YES ☐NO ☐N/A
Photographs	☐YES ☐NO ☐N/A
Duty rosters, time cards, assignment sheet	☐YES ☐NO ☐N/A
Facility incident/occurrence reports	☐YES ☐NO ☐N/A
Toxicology reports	☐YES ☐NO ☐N/A
Other (specify) _____	☐YES ☐NO ☐N/A

I HEREBY DECLARE AND AFFIRM under the penalties of perjury that the foregoing information is true and correct, to the best of my knowledge, information and belief.

_____ _____

Date Signature