COMPLAINT FORM

Please use one form per individual. *** denotes required information.**
Complete the form by typing directly into this form or,
Print the form and clearly print the information with (non-erasable) ink.
Illegible complaints will be returned for clarification.
Anonymous complaints are not accepted.
All complaints **must** be signed with (non-erasable) ink.
Return the completed Complaint Form to:
mbon.complaintsinvestigations@maryland.gov
or
Maryland Board of Nursing
Complaints & Investigations Division
4140 Patterson Avenue
Baltimore, MD 21215-2254
or
Fax: 410-358-3530

FOR OFFICE USE ONLY:
RECEIVED BY BOARD: _____/_____/_____
CURRENT NIS#: _____
PREVIOUS NIS#: _____
PREVIOUS NIS#: _____

1. *What is the practice area of the person?

- ■ 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. Provide information about the practitioner?

Full Name: _____
*First Middle *Last

Date of Birth: _____/_____/_____ ***Certificate or License Number**: _____

Home Address: _____

City: _____ State: ____ Zip code: _____ Phone: (___) _____-_____

email: _____

Place of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip code: _____ Work Phone: (___) _____-_____

3. *Who are you (<u>all fields must be completed</u>)?

Name: _____
*First Middle *Last

Full Address: _____

Phone: (___)_____-_____ email (optional): _____

Employers Only: *Agency or facility name: _____

*Title of Complainant: _____ email: _____

*Business Address: _____

City: _____ State: _____ Zip Code: _____ Work Phone: (___)_____-_____

Employer's Fax Number: (___)_____-_____

Was the employee terminated? ☐ YES ☐ NO If yes, 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	Regulatory agency	☐YES	☐NO
Law Enforcement	☐YES	☐NO	Concerned citizen	☐YES	☐NO

5. *Does the licensee/certificate holder know you are making this complaint? ☐ YES ☐NO

If no, state reason _____

_____

6. *Provide the date and location of the incident?

Date: Place:

_____/_____/_____ _____

_____/_____/_____ _____

7. *Who witnessed the incident you are complaining about?
Provide the name, address and telephone number of any witnesses, including physicians, co-workers or other employees. ***If no witnesses, indicate "No witnesses" on first line.***

Name	Address	Phone
_____	_____	(___)_____-_____
_____	_____	(___)_____-_____
_____	_____	(___)_____-_____
_____	_____	(___)_____-_____
_____	_____	(___)_____-_____

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

If yes, to whom_____

9. ***What is the complaint?** *PRINT clearly the details of the incident you are reporting. Use additional pages as necessary. Number, date and sign each additional page at the end of each page.*

10. *What evidence are you including with this 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
Other (specify) _____	☐YES	☐NO	☐N/A
Other (specify) _____	☐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	Your Name (Print)	Your Signature (Signature is required)