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## **COMPLAINT RESPONSE FORM**

Please complete and return the form in the envelope provided within 15 days of receipt of this notice. Please PRINT legibly or type your responses.

ame and License/Certification#:
hone: <u>( )</u> email:
ull Address of Residence:
urrent Employer:
urrent Employer Address:
urrent Employer Phone: ( ) email:
What is your recollection of events leading up to and including the incident that resulted in a complaint to Maryland Board of Nursing regarding your practice and/or behavior? (Use additional pages as needed)

. What st	eps have you taken to change or improve yo	ur practice, if any, since the alleged incident?
		rmation you would like to provide to the Maryland tter. You may leave blank if this does not apply to you.
	ECLARE AND AFFIRM under the penalties of perjury dge, information and belief.	v that the foregoing information is true and correct, to the best
Date	Your Name (Print)	Your Signature (Signature is required)