EMPLOYER COMPLAINT REPORT

Nurse/Nursing Assistant Against Whom Complaint is Made:

Name: _____ License or Certificate Number: _____

License Type: CRNA _____ APRN _____ RN _____ LPN _____ CNA _____ MA-C _____

Date(s) of event or incident: _____ Approximate time: _____

Shift worked by nurse at the time of incident: Shift start time: _____ Shift end time: _____

Number of patients assigned to nurse at time of incident: _____

Location of event or incident:

_____

_____

Describe the incident(s):

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Witness name(s)	Nursing license # (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____

*Name(s) of client(s) involved in incident	Medical Record Number
_____	_____
_____	_____
_____	_____
_____	_____

*The Nevada State Board of Nursing is aware of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Pursuant to 45 CFR 164.512(f)(1)(ii)(C), a covered entity may disclose protected health information to the Nevada State Board of Nursing as a body that conducts investigations.

Your Contact Information (Please print):

Staff may need to contact you for additional information and/or clarification.

Employer name: _____

Your full name: _____ Job title: _____

Address:_____

Telephone: _____ Email: _____

_____ _____

Signature Date

Please submit this form; you may include additional pages as needed along with any documentation to:

Nevada State Board of Nursing
5011 Meadowood Mall Way, Suite 300
Reno, Nevada 89502-6547
OR
Fax: (775) 687-7707
Email to: nursingboard@nsbn.state.nv.us