

COMPLAINT REGISTRATION FORM

PERSON MAKING REPORT	
Name and Title:	
Address of Person Making Report:	
City:	State: Zip:
Contact Information	
Home Phone:	Work Phone:
Cell Phone:	Email:
Reporter's Relationship to the Nurse:	
Patient	Self Co-worker Patient's Treating Professional Nurse's Treating Professional Other
NURSE BEING REPORTED	
Name and Title of Nurse:	
Minnesota License Type and Number:	
RN	LPN Applicant Advanced Practice Registered Nurse: CNS CNM CNP CRNA
Name of Employer, Business or Company:	
Street address:	
City:	State: Zip:
Home Address of Nurse Being Reported (if known):	
City:	State: Zip:
Nurse's Contact Information	
Home Phone:	Work Phone:
Cell Phone:	Email:
PRACTICE BREAKDOWN INFORMATION	
Date of event which prompted the report:	
Was the incident reported to another agency or law enforcement? NO YES	
If Yes: Who was it reported to?	What date was it reported? Case #:
What was the outcome?	
Was the incident reported to the employer? NO YES	
If Yes: What date was it reported?	What was the outcome?
Type of Employer or Facility	
Hospital APRN Clinic Assisted Living Clinic Correctional Facility Detox Center Dialysis Center Halfway House Home Care Agency Long Term Care	Managed Care Organization Public Health Agency Rehab Center School Surgical Center Telehealth Temporary Employment Agency Treatment Center Urgent Care Other: _____

STATEMENT OF COMPLAINT

Description of Incident: To assist the Board in its review, please describe the practice breakdown or event of concern using as much relevant information as possible. Be sure to include specific information, such as dates, times, location, etc. If you are authorized to do so you may attach additional pages and/or pertinent records. The Board may remove patient identifiers from records submitted. Please note: the Board does not routinely contact complainants for additional information.

Additional Records Attached: NO YES

Notice of Rights: The information you provide is classified as confidential under the Minnesota Data Practices Act. This form is offered so the Board may properly and thoroughly evaluate and investigate this report, and if necessary, use this information in any administrative or legal proceeding. Recognizing the Board's need to verify and potentially legally pursue this report, I authorize the Board, its agents, and/or agents of the Office of the Attorney General representing the Board to disclose this information to those they reasonably believe have a need to know.

Attestation: I attest that all statements contained in this document are true and complete to the best of my knowledge and belief.

I request the Board of Nursing communicate with me primarily through email.

Signature - Complainant

Date

Submit the completed Complaint Registration form to the Board office. The form can be emailed, faxed, or mailed.

Email: complaints.nursing.board@state.mn.us

Fax: 651-688-1841

Mailing Address: 1210 Northland Drive Suite 120, Mendota Heights, MN 55120