

EMPLOYER OR AGENCY COMPLAINT REGISTRATION FORM

EMPLOYER OR AGENCY MAKING REPORT

Name and title of person filing report:

Employer or Agency Name:

Address of Employer or Agency:

City: State: Zip:

Contact Information of person filing report:

Home Phone: Work Phone:

Cell Phone: Email:

Name and Address of Investigation and HR Records:

Same as Above

City: State: Zip:

Reporter's Relationship to the Nurse:

Employer HPSP MDH/DHS State Agency Insurer Law Enforcement or Court

NCSBN, National Data Banks Staffing Agency Federal Agency 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 Agency:

Street address: **Same as Above**

City: State: Zip:

Location of Nurse's work site: YES NO: Include work site address in the Description of Incident

Nurse's Contact Information

Home Address of Nurse Being Reported (if known):

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: Email:

Nurse's position or assignment at the time of the incident:

Dates of employment:

PRACTICE BREAKDOWN INFORMATION

Date of event that prompted the report:

Was the incident reported to another agency or law enforcement? NO YES

If Yes, who was it reported to: Case #:

What date was it reported:

What was the outcome:

Was the incident reported to the employer: No Yes

If Yes, what date was it reported:

Previous discipline and/or counseling by facility for related/same incident? NO YES

What was the outcome: Discipline Coaching Improvement Plan Re-education

Was the Nurse: Retained Terminated Resigned in lieu of termination Resigned

Type of Employer or Facility

- | | |
|-----------------------|-----------------------------|
| Hospital | Managed Care Organization |
| APRN Clinic | Public Health Agency |
| Assisted Living | Rehab Center |
| Clinic | School |
| Correctional Facility | Surgical Center |
| Detox Center | Telehealth |
| Dialysis Center | Temporary Employment Agency |
| Halfway House | Treatment Center |
| Home Care Agency | Urgent Care |
| Long Term 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.

(This area is intentionally left blank for the complainant to provide a detailed description of the incident.)

Provide employment records, investigations, supervisor's file or any other records relevant to the incident.

Additional Records: OHFC Report Other State Board Order Employment Records
 CD/Video/Flash Drive Other: _____

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.

(This area is intentionally left blank for the complainant to provide a signature and date.)

Signature - Complainant **Date**