State of Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

COMPLAINT FORM

All complaints are kept confidential pursuant to Section 4723.28(I), ORC and are not a public record.

Instructions: You may download this form, complete it on your computer, save it as a Word document, and e-mail it as an attachment, to complaints@nursing.ohio.gov. Or you may fax the completed form to 614-995-3686 or 614-995-3685, or send via regular mail it to the Board's Office, Att'n Compliance Unit, at the address listed above in the letterhead. If you have questions, please call 614-466-9564.

Under HIPAA, the Board is a health oversight agency to whom release of PHI is a permitted disclosure without patient authorization. 45 CFR 164.512(d).

Complainant Information

Date _____

Name of person filing complaint and Title/Position (if applicable) _____

Home Address _____
Include City, State & Zip

Home Telephone _____ E-Mail Address _____

Filing on behalf of an agency or facility? ☐ Yes ☐ No (If yes, please provide information requested below)

agency/facility name _____

agency/facility address_____
Include City, State & Zip

agency/facility telephone _____ Your E-Mail Address (at facility) _____

Complaint/Incident Information

Please provide as much information as possible. The Board understands that you may not know all of the information.

Name (of the person you are reporting to the Board)_____ Date of incident_ ___

Home Address _____
Include City, State & Zip

Home Telephone #_____ E-Mail Address_____

Please check
☐ Advanced Practice Nurse (CNP, CNS, CRNA, Certified Nurse Mid-Wife)
☐ Registered Nurse ☐ Licensed Practical Nurse
☐ Dialysis Technician ☐ Community Health Worker
☐ Certified Medication Aide ☐ No License or Certificate

License or Certificate No. _____ Last 4 SSN _____ D.O.B. _____

Employer _____ Date of Hire _____

Employer's Address _____
Include City, State, & Zip

Employer Telephone # _____ Employer E-Mail Address_____

Complaint/Incident Information Cont'd

Has the information reported in this complaint been reported to another agency or law enforcement authority?
☐ Yes ☐ No

If yes, please specify and list the contact person _____
Was the nurse/dialysis techician/community health worker/certified medication aide terminated from employment due to this incident? ☐ Yes ☐ No

If yes, please list effective date _____

Please provide below a brief description of complaint or violation, including names of witnesses and/or victims: (please type or print neatly) **Please send all related documentation and witness statements confirming the violation.**

_____

Please Note: if you are an employer and are reporting a nurse who has been involved in a practice breakdown (including but not limited to documentation issues, failure to follow physician's orders, failure to assess a patient, failure to perform treatments, and medication errors) please complete the Supplemental Information Form (available on the Board's website at www.nursing.ohio.gov.

Please provide names, addresses and telephone numbers of witnesses below:

Witness #1 _____
Name

_____
Address line 1

_____
Address line 2

_____
Telephone # and/or e-mail address

Witness #2 _____
Name

_____
Address line 1

_____
Address line 2

_____
Telephone # and/or e-mail address

Witness #3 _____
Name

_____
Address line 1

_____
Address line 2

_____
Telephone # and/or e-mail address

Witness #4 _____
Name

_____
Address line 1

_____
Address line 2

_____
Telephone # and/or e-mail address