



Nevada Department of Health and Human Services
Nevada State Health Division

Bureau of Health Care Quality and Compliance (HCQC)
(Formerly: The Bureau of Licensing and Certification)

COMPLAINT FORM

GENERAL INFORMATION

Complainant

Patient/Resident/Client

NAME _____
ADDRESS _____
APT _____
CITY _____
STATE _____ ZIP _____
EMAIL _____

NAME _____
ADDRESS _____
APT _____
CITY _____
STATE _____ ZIP _____
DOB _____

RELATIONSHIP TO PATIENT SELF _____ FAMILY _____ FRIEND _____ FACILITY STAFF _____

YOUR PHONE NUMBERS

HOME _____ CELL _____ WORK _____

FACILITY INFORMATION

GROUP CARE ___ / SKILLED NURSING ___ / HOSPITAL ___ / OTHER ___

FACILITY INFORMATION

NAME OF 1ST FACILITY _____
ADDRESS _____
CITY _____

UNIT/FLOOR/ROOM # _____
PHONE _____
STATE _____ ZIP _____
DISCHARGE DATE _____

NAME OF 2ND FACILITY _____ ADMITTED ON ____/____/____
 ADDRESS _____ FROM _____
 _____ DISCHARGED ON ____/____/____
 CITY _____ To _____
 STATE _____ ZIP _____
 ROOM/HALL _____ (IF KNOWN) DOB _____
 PHONE _____ / ____/ ____

IS THE PATIENT/RESIDENT/CLIENT STILL IN THE FACILITY? Yes ____ No ____

DO YOU WANT TO REMAIN ANONYMOUS Yes ____ No ____

(In order for this to remain confidential, Information on the Incident, Patient Name and Dates of incidents MUST still be provided for the bureau to do a thorough investigation – If confidential, you will NOT be notified of the findings of the investigation.)

INCIDENT

DATE _____ TIME OF DAY _____ CONCERNS ONGOING? Yes ____ No ____

PLEASE DESCRIBE WHAT AND HOW THE INCIDENT HAPPENED

OTHERS INVOLVED *(I.E.: STAFF, VOLUNTEERS, FAMILY MEMBERS, OTHER PATIENTS OR RESIDENTS, VISITORS - IF R.N., P.T., R.T., OR C.N.A. PLEASE ADVISE)*

NAME _____ TITLE _____ PHONE _____
 NAME _____ TITLE _____ PHONE _____
 NAME _____ TITLE _____ PHONE _____

WITNESSES *(CAN BE OTHER STAFF, VOLUNTEERS, FAMILY MEMBERS, OTHER PATIENTS/RESIDENTS/VISITORS)*

NAME _____ TITLE _____ PHONE _____
 NAME _____ TITLE _____ PHONE _____
 NAME _____ TITLE _____ PHONE _____

DID YOU SPEAK TO ANYONE ABOUT THE PROBLEM?

OMBUDSMAN (**AGE 60+ ONLY**) _____ CHARGE NURSE _____ DIRECTOR OF NURSING (DON) _____
 SOCIAL WORKER _____ MANAGER _____ CEO _____ ADMINISTRATOR _____
 MEDICAL DIRECTOR _____ OTHER STAFF _____ LAW ENFORCEMENT _____
 CITY _____ CASE/REPORT # _____

HAVE YOU TAKEN ANY ACTIONS? YES _____ NO _____
WHAT WAS DONE

HAS ANYONE AT THE FACILITY TRIED TO ADDRESS THE SITUATION? YES _____ NO _____

How?

HAS THIS HAPPENED BEFORE TO THE SAME INDIVIDUAL, OR TO OTHERS? YES _____ NO _____

DETAILS (IF YOU KNOW THEM)

OTHER PERTINENT INFORMATION

I WISH TO SUBMIT THIS COMPLAINT FOR REVIEW AND REQUEST THAT I BE NOTIFIED AT THE CONCLUSION OF THE INVESTIGATION REGARDING THE DISPOSITION OF THIS COMPLAINT.

SIGNED: _____

EMAIL _____ DATE: _____

This form cannot be emailed, please save and print.

MAIL TO:

OR

FAX TO:

***THE BUREAU OF HEALTH CARE QUALITY & COMPLIANCE
4220 So. MARYLAND PARKWAY, SUITE D-810
LAS VEGAS, NV 89119***

FAX # : 702-486-6520

***THE BUREAU OF HEALTH CARE QUALITY & COMPLIANCE
727 FAIRVIEW DRIVE, SUITE E
CARSON CITY, NV 89701***

FAX # : 775-684-1073

SAVE

PRINT