RESET FORM

MINNESOTA BOARD OF NURSING

1210 Northland Drive Suite 120, Mendota Heights, MN 55120
Voice 612-317-3000 Fax: 651-688-1841 TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: complaints.nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

# COMPLAINT REGISTRATION FORM

## PERSON MAKING REPORT

**Name and Title:**

Address of Person Making Report:

City: State: MN 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: MN Zip:

**Home Address of Nurse Being Reported (if known):**

City: State: MN 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:_____

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## 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