STATE OF NEVADA

BRIAN SANDOVAL
Governor

ROMAINE GILLILAND
Director

RICHARD WHITLEY, MS
Administrator

TRACEY D. GREEN, MD
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS PROGRAM
4150 Technology Way, Suite 101
Carson City, Nevada 89706
Telephone: (775) 687-7590 · Fax: (775) 687-7595

COMPLAINT FORM

GENERAL INFORMATION

Complainant

NAME _____

ADDRESS_____

CITY _____

STATE _____ **ZIP** _____

EMAIL _____

Patient/Facility/Agency

NAME _____

ADDRESS_____

CITY _____

STATE _____ **ZIP** _____

DOB _____

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

YOUR PHONE NUMBERS

_____ **HOME**

_____ **CELL**

_____ **WORK**

(EMS Office Use Only)

Information Collected by: _____ Date: _____

Which Investigator Notified: _____ Date: _____

Date Entered in Database: _____

AGENCY INFORMATION

GROUND AMBULANCE ___ / AIR AMBULANCE ___ / OTHER ___

NAME OF AGENCY _____ UNIT NUMBER OR CREW IF KNOWN _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

FACITLITY INFORMATION

NAME OF 1ST FACILITY_____ ADMITTED ON ___/___/___

ADDRESS _____ FROM _____

_____ DISCHARGED ON ____/____/_____

CITY _____ TO _____

STATE _____ ZIP _____

ROOM/HALL _____ (IF APPLICABLE) 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 ___ EQUIPMENT ISSUE? 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.)

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?

CHARGE NURSE OR SUPERVISOR ____

OTHER AGENCY ____ MEDICAL DIRECTOR ____ 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: _____

MAIL TO:

THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS
4150 TECHNOLOGY WAY, SUITE 101
CARSON CITY, NV 89706
FAX #: 775-687-7595
E-MAIL: bsullivan@health.nv.gov