COMPLAINT FORM

GENERAL INFORMATION

**Complainant**

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<th>Name</th>
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<td>Address</td>
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<tr>
<td>City</td>
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<tr>
<td>State</td>
<td>ZIP ___________________</td>
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<td>Email</td>
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RELATIONSHIP TO PATIENT  

SELF ______  FAMILY ______  FRIEND ______  FACILITY STAFF ______

**Patient/Facility/Agency**

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<td>ZIP ___________________</td>
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<tr>
<td>DOB</td>
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YOUR PHONE NUMBERS

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<tr>
<th>Home</th>
<th>Cell</th>
<th>Work</th>
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(EMS Office Use Only)

Information Collected by: ______________________  Date: ____________

Which Investigator Notified: ______________________  Date: ____________

Date Entered in Database: ______________________

4/2022
AGENCY INFORMATION

GROUND AMBULANCE ___ / AIR AMBULANCE ___ / OTHER ___

NAME OF AGENCY ________________________________
UNIT NUMBER OR CREW IF KNOWN ____________________
ADDRESS ________________________________
PHONE ________________________________
CITY ________________________________
STATE ____________  ZIP ____________

FACILITY 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.)

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

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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 SERVICES PROGRAM
4126 TECHNOLOGY WAY, SUITE 100
CARSON CITY, NV 89706
FAX #: 775-687-7595
E-MAIL: bsullivan@health.nv.gov