Steve Sisolak
Governor

Richard Whitley, MS
Director

Department of Health and Human Services

Division of Public and Behavioral Health

Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

COMPLAINT FORM

GENERAL INFORMATION

Complainant		**Patient/Facility/Agency**	
NAME	______________	NAME	______________
ADDRESS	______________	ADDRESS	______________
CITY	______________	CITY	______________
STATE ________ ZIP ________		STATE ________ ZIP ________	
EMAIL	______________	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 SERVICES PROGRAM
4126 TECHNOLOGY WAY, SUITE 100
CARSON CITY, NV 89706
FAX #: 775-687-7595
E-MAIL: bsullivan@health.nv.gov