Washington State Department of Health
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia WA 98504-7864

# Complaint/Report Form

*(Please Type or Print Legibly)*

Today's Date: _____

1. Your Information:

Name: ☐ Mr. ☐Mrs. ☐Miss ☐Ms. _____
*First* *Middle* *Last*

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email Address: _____

Are you filing this report on behalf of a healthcare facility? ☐Yes ☐No

If yes please specify facility name and your position title:

_____ _____
*Facility Name* *Position Title*

2. Nurse Information: *(Please complete as much as possible, if unknown leave blanks)*

Type of nurse:

☐ Registered Nurse (RN) ☐ Licensed Practical Nurse (LPN) ☐ Advanced Registered Nurse Practitioner (ARNP)
☐ Nursing Technician

Nurse Name: _____ ☐ Female ☐ Male

License Number: _____ . _____ . _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ - _____

3. Patient Information:

Full Name: _____ ☐ Female ☐ Male

Date of Birth: _____ Date of Death *(if applicable)* _____

4. Specific Report Information: *(Please complete as much as possible, if not applicable leave blank)*

Date(s) of Incident: _____

Name of facility* where conduct occurred: _____

Have you reported this incident to anyone else? ☐Yes ☐No

If yes please specify who you reported to and when: _____

_____

**This report will be shared with the Department of Social and Health Services (DSHS) if the conduct occurred in a DSHS facility or to fulfill other reporting requirements.*

| **Please provide a brief summary of your specific concern(s). Attach additional pages if needed.** |
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| **If you are an employer or supervisor, describe the following:** | |
|---|---|
| Actual or potential harm to patient | |
| Pattern(s) of practice errors | |
| Prior disciplinary/counseling actions | |
| Corrective action taken | |
| Employment terminated ☐ Yes ☐ No | Resignation in lieu of termination ☐ Yes ☐ No |

***Public Disclosure:*** *The Identity of a whistleblower (patient, employee of respondent, healthcare professional) who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility will not be released to the public. The Department of Health is required by law to release copies of this complaint form and/or any other documentation you submit in regards to this report upon receiving a public disclosure request. This includes releasing copies to the person identified in the report as the nurse.*

Send completed form by mail to:
**Washington State Department of Health**
**Nursing Care Quality Assurance Commission**
**P.O. Box 47864**
**Olympia WA 98504-7864**

by fax to: **(360) 236-3204**
by email to: **nursingcomplaints@doh.wa.gov**