



## Complaint Form

Today's Date: \_\_\_\_\_

### 1. Your Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Work ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Home ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### 2. Information about the nurse

Type of nurse Check One:

Registered Nurse (RN)  Licensed Practical Nurse (LPN)  Nurse Technician

Advanced Registered Nurse Practitioner (ARNP)

Name of nurse: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 3. Resident/Guest/Patient Information

Full Name (if different from above) \_\_\_\_\_

Date of Birth (of patient, if complaint involves a patient) \_\_\_\_\_

Date of incident: \_\_\_\_\_

Facility where conduct occurred: \_\_\_\_\_

4. **Please describe your complaint on the next page.** Include the name, title and phone number of other patients, witnesses or staff members involved in the incident. Send completed form to:

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

**Or fax to: 360.236.4738**

