COMPLAINT AND REPORT FORM (NURSES)

Public disclosure statement: 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 regard to this report upon receiving a public disclosure request. This includes releasing copies to the person you identified in the complaint/report as the nurse.

DATE:

Your Information

Enter your information below.

First Name:
Middle Name:
Last Name:

Enter your contact information below.

Address:
City:
State:
Zip:
Daytime Phone:
Cell Phone:
Email Address:

Are you filing this complaint/report on behalf of a healthcare facility?

	Yes
	No

If yes, enter the information below.

Facility name:
Your position title:

Nurse Information

The complaint/report is about a(n):

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

Nurse

Name:	
Gender:	
	Male
	Female
	Other/unknown

License number:
Address:
City:
State:
Zip:
Phone number:

Patient Information

Enter information regarding the patient below.

Name:	
Gender:	
	Male
	Female
	Other/unknown

Date of birth:
If applicable, date of death:

Specific Report Information

Enter information about the incident below.

Date(s) of the incident:
Name of facility* where conduct/incident occurred:

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

Have you reported this conduct/incident to the Department of Social and Health Services (DSHS)?

	Yes
	No

Have you reported this conduct/incident to anyone else?

	Yes
	No

If yes, who did you report the conduct/incident to? Please provide:

Name(s):

Position(s):
Date(s) you reported to them:

Do you have documents relevant to your complaint (such as medical documents, investigative reports, test results or other relevant documentation)?*

	Yes
	No

*If you need to send documents: email copies to the Discipline Unit (recommended), or you may send them via the address or fax provided below.

Did the situation involve discrimination?

	Yes
	No

What do you believe is the basis of the discrimination? (check all that apply)

	Age
	Race
	Ethnic origin
	Citizenship/ Immigration status
	Religion/ Ideology
	Sex
	Weight
	Socio-economic / Housing Status
	Relationship/ Marital arrangement
	Disability (including mental, physical, developmental or learning disabilities)
	Criminal Record
	Sexual orientation
	Gender identity/ Expression
	Language/ Accent
	Close relationship with a person identified by one of the above types
	Other (Please Explain):

Please describe the discrimination that occurred:

Please provide a brief summary of your specific concern(s) below.

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:

Was employment terminated, or did the nurse resign in lieu of termination?

	Yes – Terminated
	No – Not Terminated
	Yes – Resigned in Lieu
	No – Did not Resign

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Board of Nursing
111 Israel Road SE, MS 47864
Tumwater, WA 98504

AUTHORIZATION TO RELEASE YOUR NAME & IDENTITY

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health/Washington State Board of Nursing about the improper quality of care by a health care provider, or in a health care facility, as defined in RCW 43.72.010 shall remain confidential..."

I understand that my identity as the complainant may be confidential pursuant to RCW 43.70.075 (DOH Whistleblower Statute). By marking the "Yes" box, I waive my right to confidentiality, and I authorize the Washington State Board of Nursing to release my identity to:

- the Nurse you filed a complaint against,
- other persons who are reasonably necessary to the investigation, and/or
- for use in any related discipline hearing resulting from your complaint.

YOUR WAIVER AUTHORIZATION/DENIAL

For the sole purpose of investigating my complaint and pursuing disciplinary action proceedings, I hereby waive confidentiality and consent to the release of my identity.

☐ YES ☐ NO*

*I understand this denial may impair the Washington State Board of Nursing's ability to pursue investigation of this matter and any disciplinary actions.

Signature:
Date:
Printed Name: (please include middle initial)
Date of Birth:
Phone Number:

Once you have completed this form, please scan and email it to NursingComplaints@doh.wa.gov

If you do not have access to email, please mail it to the address at the top of the page, attention Complaint Intake