312 Whittington Parkway, Suite 300
Louisville, Kentucky 40222-5172

Phone: (502) 429-7971
Fax: (502) 429-3353
KBNdisciplinealert@ky.gov

CONSUMER COMPLAINT FORM

This form should be completed by person(s) with direct knowledge of the allegation (i.e., patient, family member, significant other, etc.) if the allegation concerns the conduct of a licensee (nurse, dialysis technician, or licensed certified professional midwife).

Licensee's Name: ____
(Last Name, First Name, Middle Name, Maiden Name)

Licensee's Date of Birth and Social Security Number: ______________________________

____

Licensee's Address: ____
(Street Address)

____
(City/State/Zip Code)

____
(Licensee's Home or Cell Phone Number/Email Address)

Licensee's License/Credential Number(s): ______________________________

State where Licensed/Credentialed: ______________________________

Licensee's DEA Number(s) (if applicable): ______________________________

Licensee's Employer:

____
(Name of Facility)

____
(Street Address)

____
(City/State/Zip Code)

____
(Phone Number/Email Address)

____
(Contact Person's Name and Position)

____
(Contact Person's Phone Number/Email Address)

Facility where incident(s) occurred:
(If different from Employer)

(Name of Facility)

(Street Address)

(City/State/Zip Code)

(Phone Number/Email Address)

(Contact Person's Name and Position)

(Contact Person's Phone Number/Email Address)

Your Contact Information:

(First Name and Last Name)

(Street Address)

(City/State/Zip Code)

(Phone Number/Email Address)

Were you a patient of this licensee? Yes ☐ No ☐

If so, during what timeframe? ______________________

What is the nature of your relationship to the licensee? ______________________

Description stating the exact nature of your complaint(s) against the licensee:

Did you report this to the licensee’s employer? Yes ☐ No ☐

If so, who was it reported to? ______________________________

Have you filed this complaint with any other person, organization, law enforcement agency, or regulatory agency? Yes ☐ No ☐

If so, whom? Provide any information that could be helpful to locate the status of this complaint such as agency name, complaint/case number, how the complaint was filed, contact information, etc.

____

____

____

For Purposes of Patient Identification:

Patient’s Full Name:	Patient’s Date of Birth:	Patient’s SSN: (Last 4 digits only)	Date(s) of Service:

Comments related to the Patient(s):

____

____

____

Was there any witness(es) to the incident(s)? Yes ☐ No ☐

Name and Contact information of the witness(es) to the incident(s)?

____

____

____

By signing my full name, I hereby declare and affirm under the penalties of perjury that the matters set forth in the foregoing complaint are true and correct to the best of my knowledge, information, and belief:

____
(Printed Name)

____
(Signature)

Date: ____

Do you wish to be notified of the Board's final resolution of the case? All notifications will be sent to the email address provided by you in this complaint. Yes ☐ No ☐

Records and/or additional information (texts, emails, photos, videos, etc.) related to this complaint should be submitted to the Kentucky Board of Nursing Investigation Branch by email to KBNdisciplinealert@ky.gov or by fax to (502) 429-3353.

If you are the patient/client or the patient's/client's parent or legal guardian, complete the next page.

Patient/Client Use Only:

Waiver of Privilege
Agreement to Release Records

Upon receipt of a photostatic or other copy thereof, you are authorized to release to the representative of the Kentucky Board of Nursing for inspection and copying all records in your possession pertaining to named patient(s) and/or client(s), to discuss with them fully any information you may have about the named patient(s) and/or client(s), and to furnish them a full report concerning named patient(s) and/or client(s).

This authorization includes medical records, including all hospital records, psychiatric and psychological records, records of physicians and other medical personnel, records of drug abuse, records of alcohol abuse, prescriptions and drug records, and any and all records relating to my physical and mental condition of named patient(s) and/or client(s).

Prohibition of Re-disclosure: This information has been disclosed in compliance with Federal Regulations (42 CFR Part2) which prohibits further disclosure of this information except with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

For Purposes of Identification:

Patient's Full Name:	Patient's Date of Birth:	Patient's SSN: (Last 4 Digits Only)	Date of Occurrence(s):

By typing my full name, I hereby declare and affirm under the penalties of perjury that the matters set forth in the foregoing complaint are true and correct to the best of my knowledge, information, and belief:

____
(Printed Name)

____
(Signature)

Date: ______________________________________

Do you wish to be notified of the Board's final resolution of the case? All notifications will be sent to the email address provided by you in this complaint. Yes ☐ No ☐