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

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

FACILITY COMPLAINT FORM

This complaint should be completed by the licensee's employer and/or the facility where the licensee was practicing when the incident(s) occurred 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: _____

State where Licensed/Credentialed: _____

Licensee's DEA Number (if applicable): _____

Licensee's Employer: _____
(Name of Facility

_____
(Street Address)

_____
(City/State/Zip Code)

_____
(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)

_____
(Contact Person's Name and Position)

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

Contact person subpoena should be issued to:

_____
(Name of Facility)

_____
(Street Address)

_____
(City/State/Zip Code)

_____
(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)

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

Licensee Suspension Date: _____ (mm/dd/yyyy)

Licensee Termination Date: _____ (mm/dd/yyyy)

Resigned in Lieu of Termination: Yes ☐ No ☐

Licensee Other Employment Status: _____

_____

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.

_____

_____

_____

Release of Patient Medical Records to KBN

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.

KRS 314.091(3) allows the KBN to "issue subpoenas to compel the attendance of witnesses and the production of documents in the conduct of an investigation. The subpoenas may be enforced by the Circuit Court as for contempt. Any order or subpoena of the court requiring the attendance and testimony of witnesses and the production of documentary evidence may be enforced and shall be valid anywhere in this state."

> ***Subpoenaed information, where a copy of the record, and not an original record, is provided in response, should contain a Certification of Records Form to be completed by the business or facility complying with the subpoena. A Certification of Records Form is attached to this Facility Complaint Form for your use with any documentation to be submitted to KBN.***

Pursuant to **45 CFR 164.512** the Kentucky Board of Nursing is a Health Oversight Agency engaged in oversight activities authorized by law. Consequently, the patient authorization requirements of HIPAA do not apply to KBN.

For Purposes of Identification:

Patient's Full Name:	Patient's Date of Birth:	Patient's Identifier:	Date(s) of Service:

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 ☐

CERTIFICATION OF RECORDS

I, _____, the custodian of records for _____,
(Name) (Facility Name)
certify that the attached records are true and correct reproductions of the original documents in my custody pertaining to:

_____ _____
(Name) (Alias)

Social Security Number: _____ Date of Birth: _____

Number of Pages copied: _____

The copies of records for which this certification is made are true and complete reproductions of the original or microfilmed records which are housed at the address below.

_____
(Facility Name)

_____
(Facility Address and Phone Number)

The original records were prepared in the ordinary course of business at or near the time of the act, condition, or event by a person with knowledge of the facts records. This certification is given in lieu of the custodian's live testimony or deposition.

_____
(Custodian of Records Signature)

Subscribed and Sworn to before me by_____,
(Custodian of Records)
custodian of records for _____,
(Facility Name)
this _____ day of _____, 20____.

State of _____

County of_____

Notary Public_____ SEAL

Notary ID_____

My Commission expires _____

3/2022