Nebraska Department of Health and Human Services

COMPLAINT FORM
Nebraska Department of Health and Human Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
OFFICE OF PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508 402-471-0175

PUBLIC COMPLAINT FORM TO REPORT ADVERSE ACTION OF LICENSED OR UNLICENSED HEALTH PROFESSIONAL

Non licensed general public form used to report adverse actions about Licensed or Unlicensed Practice of Professionals and or Facilities to Division of Public Health Investigations Unit

INSTRUCTIONS: (Please type or print legibly.)
Please furnish all identifying information for the complainant, the patient and all practitioners and facilities involved in the complaint. Additional pages may be added if necessary

Person Making Complaint

(1) Name: First | Middle/MI | Last | Maiden or other Name Used

Address: Street

Address: City | State | Zip

Home Telephone | Work Telephone

May we contact you at your place of employment? ☐ Yes ☐ No

This Complaint is Being Filed Against

(1) Name: First | Middle/MI | Last | Maiden

Address: Street

Address: City | State | Zip

Date of Birth | Work Phone | Home Phone

(2) Name: First | Middle/MI | Last | Maiden

Office Address: Street

Office Address: City | State | Zip

Please check your response to the below statements and then sign the form. Please remember to also fill out and sign the Release of Information Authorization form.

I agree to testify in any licensure hearings that may arise as a result of my complaint ☐ Yes ☐ No

I grant my permission for the Division of Public Health - Investigations to provide a copy of my narrative to the subject of my complaint ☐ Yes ☐ No

The statements I have made are true and correct to the best of my knowledge ☐ Yes ☐ No

Date_____ Signed_____

NARRATIVE (Please type or print legibly)

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. Attach copies of any documents you have concerning the allegations. Use additional sheets if necessary.

Release of Information Authorization

I authorize any person, including, but not limited to, hospitals, institutions, health care providers, mental health providers, clinics, employers (past and present), laboratories, attorneys, insurance companies, government agencies, or other public or private agencies to release to the Nebraska Health and Human Services and the Nebraska Attorney General's Office, their representatives, agents or employees, any and all information about me, including documents, reports, records, files, testimony or any other documents regardless of form or content.

Date of Incident:	Patient/Client's Name:

HIPAA: Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. 45CFR 164.512 (d) Standard: Uses and disclosures for Health Oversight Activities. (1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions.

A copy of this authorization shall be as valid as the original.

Name (Print or Type)	Date of Birth
Signature	Date
(or) Parent or legal guardian (if applicable)	Relationship

DO NOT WRITE BELOW THIS LINE

To:

Address:

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

❑ Facesheet	❑ History and Physical	❑ Pathology Reports	❑ Consultant	❑ Progress Notes
❑ EKG Tracings	❑ Nurses Notes	❑ Discharge Summary	❑ Laboratory Reports	❑ Imaging Reports
❑ Operative Reports	❑ Physician Orders	❑ Emergency Dept. Record		

Other: