

COMPLAINT FORM

PARTY AGAINST WHOM COMPLAINT IS MADE

Print Name _____

Nursing Facility Name _____

Address _____

PARTY MAKING THE COMPLAINT

Print Your Name _____

Address _____

Phone Number _____

NATURE OF COMPLAINT (On a separate sheet of paper, please state clearly and specifically, all charges made against the party named above. Be it known, the Administrator named above will be contacted during the investigation process.)

Will you, as the Complainant, willingly testify if a hearing should be called by the SD Board of Examiners for Nursing Facility Administrators for the purpose of pressing charges arising from this complaint?

_____ (Yes or No)

I hereby certify that the above stated charges are true and correct to the best of my knowledge. Further, I waive any requirements of confidentiality, and authorize disclosure of information as the Board or its staff deem necessary to investigate or pursue this complaint.

Signed _____

Before me personally appeared _____ whose signature appears above, and made oath and says that he/she is the identical person making this complaint and that all the foregoing statements are true and correct.

My commission expires _____
(seal)

Notary Public Signature