



## SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115  
605-362-2760 | <https://doh.sd.gov/boards/nursing/>

### Complaint Form

Pursuant to SDCL § 36-1C-2, “Any person claiming that a licensee or an applicant for a license under Title 36 has engaged in or is engaging in conduct constituting grounds for disciplinary action, as enumerated in the laws or rules of the agency, may file with the agency a written complaint. The agency shall require the complaining party to file a complaint stating the name of the applicant or licensee against whom the complaint is made and setting out, in full detail, the conduct that is alleged to be in violation and may prescribe the form on which a written complaint is made. Failure of the complainant to comply with this section is basis for the administrator to reject the complaint without further action.”

This is the prescribed form for filing a complaint regarding a licensee or applicant with the South Dakota Board of Nursing. Please complete the following information and submit copies of pertinent documents, including medical records, if available. Do not submit your original documents.

Please send this completed, signed form to the South Dakota Board of Nursing, attention: Complaints. If necessary, the Administrator may contact you for additional information, and you will be notified of a final decision. Please be aware that evaluation and investigation of a complaint is a time-consuming process.

In addition, please be aware that pursuant to SDCL § 36-1C-3, “upon receipt of a properly submitted complaint within the agency’s jurisdiction, the administrator shall serve a copy of the complaint by mail or electronic mail upon the applicant or licensee complained against.” This written complaint will be served upon the Licensee/Applicant.

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#### Complainant(s):

Name(s) of person(s) completing or contributing to this written complaint: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

*The SDBON’s Administrator may contact you if needed regarding the complaint.*

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#### Licensee/Registrant/Applicant against whom this complaint is being made:

Licensee/Registrant/Applicant Full Name: \_\_\_\_\_

Licensee/Registrant/Applicant # if known: \_\_\_\_\_

Licensee/Registrant/Applicant place of employment at time of alleged conduct: \_\_\_\_\_

Licensee/Registrant/Applicant current place of employment (if known): \_\_\_\_\_

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#### Complaint Information:

Were you the patient/individual for whom care was provided?  Yes  No

If not, for whom was care provided (name and relationship to you)? \_\_\_\_\_

What is the date of birth for person who received care (if available)? \_\_\_\_\_

Do you represent the employer of the nurse involved?  Yes  No

If so, please provide the name and contact information of the employer: \_\_\_\_\_

If so, has Licensee/Registrant/Applicant had prior warnings/disciplinary action?  Yes  No

Please provide employee history, evaluations, etc., as appropriate.

Have you contacted the Licensee/Registrant/Applicant and/or their employer about your complaint?

Yes  No      If yes, what action, if any, was taken or is being taken? \_\_\_\_\_

Has this complaint been filed elsewhere?  Yes  No

If so, with whom/what organization or agency? \_\_\_\_\_

If so, what action, if any, was taken or is being taken? \_\_\_\_\_

#### Please describe in detail the event(s) that caused you to file this complaint:

Include names, dates, locations, and any other information that you believe support the complaint. Attach extra sheets if necessary.

I certify that the above information is true and correct to the best of my knowledge.

Signature of Complainant \_\_\_\_\_ Date \_\_\_\_\_