South Dakota Board of Nursing Facility Administrators
P.O. Box 340, 1351 N. Harrison Ave. Pierre, SD 57501-0340
Ph.: 605-224-1721 Fax: 888-425-3032
E-mail: SDNFA@midwestsolutionssd.com doh.sd.gov/boards/nursingfacility

Complaint Form

Please ***type*** or ***print legibly*** and return to the above address.

PERSON REGISTERING COMPLAINT			
NAME			PHONE NUMBERS
ADDRESS			HOME ( )
CITY	STATE	ZIP	CELL ( )
EMAIL			
HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD? YES ☐ NO ☐			

COMPLAINT REGISTERED AGAINST: *(Please use the full name of the PERSON and FACILITY against whom you are filing the complaint.)*		
NAME		PHONE
FACILITY		
ADDRESS		
CITY	STATE	ZIP
EMAIL		

DETAILS OF COMPLAINT

1. DATE OF INCIDENT: _____/_____/_____

2. HAVE YOU COMMUNICATED YOUR CONCERN TO THE PERSON OR COMPANY? **YES ☐** **NO ☐**
   IF YES, ON WHAT DATE AND BY WHAT MEANS: _____

3. DID THE PERSON OR THE COMPANY RESPOND? **YES ☐** **NO ☐**
   IF YES, WHAT WAS SAID OR DONE? _____

4. WILL YOU WILLINGLY TESTIFY IF A HEARING SHOULD BE CALLED BY THE BOARD FOR THE PURPOSE OF PURSUING THIS COMPLAINT? **YES ☐** **NO ☐**

STATE YOUR COMPLAINT: (Please provide a clear and concise description of the nature of your complaint, including dates of occurrence, times, place and persons involved. Please include the names and telephone numbers of witnesses, if applicable). **If more space is needed, please attach additional sheets of paper.**

I verify that I have read the foregoing complaint and the same is true to the best of my knowledge, information and belief. I hereby waive any right of confidentiality or privilege under state law, federal law or the law of the land. I specifically acknowledge and understand that the Board may disclose confidential and privileged information as the Board or its staff deem necessary to investigate and process this complaint. I understand that a copy of this complaint will be provided to the licensee.

_____ _____

Signature of Complainant Date