# South Dakota Board of Nursing Facility Administrators

## Complaint Form

P.O. Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340
Phone: 605-224-1721
Email: SDNFA@midwestsolutionssd.com Website: doh.sd.gov/boards/nursingfacility

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

### PERSON REGISTERING COMPLAINT

**Name**

**Address**

**City** **State** **ZIP Code**

**Phone Numbers** **Home Phone**

**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**

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### DETAILS OF THE COMPLAINT

1. **Date of incident**

2. **Have you communicated your concern to the person or company?** ☐ **Yes** ☐ **No**

**If yes, provide the date and by what means**

3. **Did the person or the company respond?** ☐ **Yes** ☐ **No**

**If yes, explain 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**

### DETAILS OF THE 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.**

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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**