Department of Health & Human Services

DHHS

N E B R A S K A

Attn: Health Facility Investigations
P.O. Box 94986
Lincoln, NE 68509
Phone: 402-471-0316
Fax: 402-471-1679
Email: DHHS.HEALTHFACILITYINVESTIGATION

COMPLAINT FORM

INSTRUCTIONS:
Please furnish all identifying information for the complainant, the patient, resident or client and facilities involved in the complaint.

PERSON MAKING COMPLAINT

_____
NAME

_____
ADDRESS

_____
CITY, STATE and ZIP CODE

_____
HOME PHONE

_____
WORK PHONE

_____
CELLULAR PHONE

RELATIONSHIP TO PATIENT, RESIDENT, CLIENT: _____

May we contact you at your place of employment? YES____ NO ____

PATIENT, RESIDENT, CLIENT INFORMATION

NAME _____

DATE OF BIRTH: _____

DATE OF INCIDENT: _____

This Complaint is being filed against:

_____
FACILITY NAME

_____
STREET ADDRESS and CITY

NARRATIVE

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. You may include as an attachment any additional information or submit separate to DHHS.HEALTHFACILITYINVESTIGATIONS@NEBRASKA.GOV