South Carolina Department of Labor, Licensing and Regulation
Office of Investigations and Enforcement
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4470 • Fax: 803-896-4656

Board of Nursing
PUBLIC SUPPLEMENTAL COMPLAINT FORM

Your Name: (Include DOB and gender if you are the patient) _____

Nurse's Name: _____ ☐ Self-Report

Nurse's Relationship to You: _____

Date of Incident: _____

Location of Incident: _____

Approximate Time or Shift of Incident: _____

What specifically happened? (If more space is needed, please attach an additional sheet) _____

Who else was there or aware of it? (If possible, please give their full name, position/title, address, and phone number. If non-staff, please identify their relationship.) _____

_____

Did you report it to the facility or management? ☐ Yes ☐ No

Has this Complaint been under consideration by another agency or court? ☐ Yes ☐ No Please provide agency name, court name, case number, and status: _____

_____

If you are not the patient, please list the patient's full name, date of birth, and gender: _____

Would you be willing to travel to Columbia, South Carolina to testify if this case were to go to a panel hearing?
☐ Yes ☐ No

What documents do you have to support your complaint? Please attach COPIES of all documents. **Do not** send originals; they will not be returned to you.

☐ Medical Records
☐ Contracts
☐ Invoice/Billing Statements
☐ Receipts/Proof of Payment
☐ Correspondence
☐ Other: (Please list) _____

Have you contacted the healthcare provider to try and resolve your complaint? ☐ Yes ☐ No

If you are the patient, please complete the Authorization below:

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION AND RECORDS

IMPORTANT: THIS AUTHORIZATION DEALS WITH THE RELEASE, SHARING, DISCLOSURE, AND RECEIPT OF INFORMATION FROM YOUR MEDICAL AND HEALTH RECORDS. READ IT CAREFULLY.

I, _____ (name of patient) of _____ (address, city, state) _____ (date of birth) hereby authorize any health plan, physician, health care practitioner, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to _____ (patient name) to release, disclose and furnish copies of the following medical and health care information regarding my care and treatment related to my complaint to South Carolina Department of Labor, Licensing and Regulation, its agents and/or its attorneys (hereinafter referred to as "LLR").

_____ Signature

_____ Date