



Matthew H. Mead
Governor

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STATE BOARD OF NURSING

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Administrative Complaint Form (Must be typed or printed legibly)

Name of person registering the complaint: _____

Address: _____ Phone No.: _____

Name of person being reported: _____

License Type: _____ License/Certificate No.: _____ Expiration date: _____

Facility Name & Address (if applicable): _____

Facility Phone No.: _____ Employment Dates: _____ to _____ Employment Status: _____

Location of incident: _____ Date of incident: _____

Specifics of the Complaint: In the space below provide a detailed description of the incident, please include: dates, times, names of witnesses, names of patients (or provide other patient identifying information), observed nurse behaviors, names of other entities contacted (i.e. law enforcement, Dept. of Health, Dept. of Family Services). Please use additional paper if necessary.

You must sign this form. Per the Administrative Rules & Regulations we cannot accept anonymous complaints. The licensee/certificate holder will be notified of the complaint with an opportunity to respond.

Signature of person filing complaint Title Date