DATE RECEIVED: _____ COMPLAINT NO.: _____

# KENTUCKY BOARD OF RESPIRATORY CARE COMPLAINT FORM

Send to: Kentucky Board of Respiratory Care 2365 Harrodsburg Rd., Suite B350
Lexington, KY 40504-3335 or Fax to 859-246-2750

## Person / Hospital Filing Complaint

Name:
_____

Address: _____ City: _____ State: _____ Zip Code ____

Work Phone: ( ) - _____- _____ Home: ( ) - _____- _____

## Patient Information

(if different from person filing complaint)

Name:
_____

Address: _____ City: _____ State: _____ Zip Code ____

Day Telephone: ( )_____ Evening Telephone: ( )- _____- _____

## Relationship to person filing complaint:

_____

## Name of licensed respiratory therapist named in complaint

Name:
_____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: ( ) - _____- _____ Home: ( ) - _____- _____

## Nature of the complaint

Drug Impairment __ Falsification of documents __ Profession conduct __

Working w/o or expired licensure __ Other __ (Provide as much detail as possible.)

## Name and phone number of persons who may provide additional information

1. Name _____ Telephone: ( )_____ Type of Information _____

2. Name _____ Telephone: ( )_____ Type of Information _____

3. Name _____ Telephone: ( )_____ Type of Information _____

## Brief Summary of Complaint

(Please be as specific as possible regarding names, dates, locations and actions which you believe to be improper, unethical or unprofessional.)

By signing this complaint form, I herby certify that the information is complete and true to the best of my knowledge.

**Signature:** _____ **Date:** _____

**Kentucky Board of Respiratory Care**
**2365 Harrodsburg Rd., Suite B350**
**Lexington, KY 40504-3335**
**Phone: 859-246-2747 Fax 859-246-2750**
**Email: Tamara.McDaniel@ky.gov**