Print legibly: * is required information

If there is insufficient information to identify the correct nurse a complaint cannot be opened.

If there is insufficient information to conduct the investigation the complainant will be notified for additional information provided the complainant contact information is completed.

Mail to: Arkansas Department of Health
ATTN: Full Independent Practice Committee
4815 W. Markham St. Slot 75
Little Rock, AR 72205

*Nurse's Last Name	* Nurse's First Name	Nurse's Middle Name/Initial	
Street Address	City	State	Zip Code
License Number(s)		Date of Birth	
*Name of employer	Employer Street Address		
*City *State Zip Code		Phone	
Are you the patient?	Are you a family member?	Are you a provider?	
Complainant's Name	Complainant's Phone Number ( )	Complainant's E-mail address	
Complainant's Street Address	City	State	Zip Code
Witness's Name	Witness's Phone Number ( )	Witness's E-mail address	
Witness's Street Address	City	State	Zip Code
Witness's Name	Witness's Phone Number ( )	Witness's E-mail address	
Witness's Street Address	City	State	Zip Code
Witness's Name	Witness's Phone Number ( )	Witness's E-mail address	
Witness's Street Address	City	State	Zip Code
Patient Name(s)			

* Describe in detail what the nurse has done or failed to do that warrants review by the Full Independent Practice Credentialling Committee. Include who, what, when, and where. Patient names may be given in a complaint to a Licensing Board without violating the patient's confidentiality or HIPAA Rules.

Adopted: March 9, 2022