NHCWA Complaint Form
Please mail this form to:

National Healthcare Workers Association
Complaint Department
P.O. Box 5034
Milford, CT 06460
You can also fax this form to 202-609-9943

Complainant's Information	
Name of Person Filing Complaint:	**Relationship To Whom Complaint Is About:**
Street Address or P.O. Box:	
City:	
State:	
Zip:	
Phone (day time):	**Cell:**
Facility Information	
Name of Facility Involved:	
Street Address of Facility:	
City:	
Zip:	
If more than one facility was involved, please list additional facilities along with the address and city information:	
Person Whom Complaint is About	
Certification holder's Full Name:	
Certification Number:	
Details of the Event:	
Date of Event	
Location Where Event Occurred (i.e. unit, room, department, area, site):	
Names of Staff Members Involved in Event:	

Details of the event to include names, dates, titles of persons involved, areas of the facility, shifts, room numbers, etc (Give as much information as possible):

Did you report this event to anyone at another agency? Yes or No

If Yes, please provide the name & title of the person you reported this event to and the date it was reported:

If No, are you considering filing a complaint with another agency? Yes or No
If No please provide the reason that you are not filing a complaint with any other agency: