RISK MANAGEMENT REPORT FORM
FACILITY OR INDIVIDUAL
REPORT OF ADVERSE FINDING

Agency Receiving This Report:

☐ Kansas Board of Healing Arts: 800 SW Jackson, LL Suite A, Topeka, Ks. 66612
☐ Kansas Board of Nursing: 900 SW Jackson, #1051, Topeka, Ks. 66612
☐ Kansas Board of Pharmacy: 800 SW Jackson, #1414, Topeka, Ks. 66612
☐ Kansas Dental Board: 900 SW Jackson, 455-S, Topeka, Ks. 66612
☐ Other (provide name and address):
☐ Kansas Department of Health and Environment: 1000 SW Jackson, Suite 330, Topeka, KS. 66612

- *KDHE's Risk Management Program receives SOC III and IV reports only for licensed facilities, CNAs, and unlicensed individuals. Do not submit personally identifiable information (PII) for involved staff or patients when reporting to KDHE.*

Report: Individual or Facility (Select appropriate box below):

☐ **Individual Submitting This Report:**

Name:
Telephone:
Address:
Email Address:

OR

☐ **Facility Submitting This Report:** (NOTE: Applicable Statutes: K.S.A. 65-4216, 65-4915, 65-4921, 65-4922, 65-4923(a)(1) and (2), 65-4924, 65-4925, 65-4927, 65-4929, 65-28,121 and 65-28,122; Regulations: K.A.R. 28-52-2, 3, and 4. No liability for reporting: K.S.A. 65-4909, 65-4926, and 65-2898).

Facility Name:
CCN#
(CCN# is CMS Certification Number; If your facility is not CMS Certified, please list State ID#(s)/KDHE Facility #(s) if applicable)
Facility Type: ☐ Hospital ☐ Psychiatric Hospital ☐ Ambulatory Surgical Center ☐ Other
Name of Contact Person/Risk Manager:
Telephone No.:
Facility Address:
(Include Street, City, State, and Zip)
Email Address:

RISK MANAGEMENT REPORT FORM
FACILITY OR INDIVIDUAL
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Incident Identification:

IRN (Incident Report Number(s) Assigned by Facility, if facility report and if applicable):
Date of Incident:
Medical Record No. (If known):
Patient Name: Patient Date of Birth:
Location of Incident:
(Facility, department, unit, or other location descriptor)
Licensee Involved:
(Facilities must submit a separate form for each licensee involved). Include Name, Licensee Number and Last 4 digits of SSN if known.

Description of Incident: (May attach separate sheet)

Description of Education, Correction, Disciplinary Action or Sanction: (If known) (May attach separate sheet)

Additional Records Related to This Incident: (Other treatment, coroner, external consultant, etc.)

Type of Incident:

- ☐ Fall
- ☐ Abuse, neglect or Exploitation
- ☐ Assessment/treatment
- ☐ Professional licensure event
- ☐ Delay
- ☐ Facility process or system-related
- ☐ Scope of Practice
- ☐ Impairment due to drug/alcohol
- ☐ Impairment physical, mental, emotional, cognition
- ☐ Falsification
- ☐ Documentation of Narcotics
- ☐ Medication Error
- ☐ Improper Procedure
- ☐ EMTALA-Related
- ☐ IV line mix-up
- ☐ Drug Diversion
- ☐ Unprofessional conduct
- ☐ IV infiltration
- ☐ Other: (explain)

_____ _____
Date Signature of Individual/Risk Manager Submitting Report

Privileged and Confidential pursuant to K.S.A. 65-4915 and K.S.A. 65-4921 et seq.

This form was jointly developed and approved by the Kansas Hospital Association, the Kansas State Board of Nursing, the Kansas State Board of Healing Arts and the Kansas Department of Health and Environment. (Revised May 2019)

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RISK MANAGEMENT REPORT FORM / REPORT OF ADVERSE FINDINGS
INDIVIDUAL COMPLAINT FORM

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Pursuant to law the Kansas State Board of Nursing may exercise discretion in deciding what to investigate, absent a sworn (notarized or verified) Complaint.

Optional:
Complete the below portion if you desire to make the investigation of this matter a mandatory duty of the Board of Nursing.

VERIFIED COMPLAINT to Kansas State Board of Nursing

Verification: I verify under penalty of perjury, the above information is true and accurate to the best of my knowledge, signed:

_____ _____
Signature Date

Print Name: _____

NOTARIZED COMPLAINT to Kansas State Board of Nursing

State of _____)
County of _____)

_____, being first duly sworn states that he/she has read the forgoing report consisting of _____pages and knows the contents thereof; and that the same is true and correct to the best of his/her knowledge, information and belief.

_____
Signature of Reporting Person

Subscribed and sworn to/before me this _____ day of _____, 20__.

My commission Expires:_____

_____
Notary Public

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