HAWAI'I NURSES & HEALTHCARE PROFESSIONALS (HNHP) INTAKE FORM

Please fill out this form as completely as possible. If we need information in addition to what is on this form (such as supporting documents), we will contact you. This form and the information contained within are for HNHP internal use only and any information you provide will be kept confidential. All information provided will assist HNHP in investigating your concern or grievance. Please attach additional pages as necessary to give all pertinent information. We will respond as quickly as possible. Email copy to info@hnhp.org

CONTACT INFORMATION

First Name *

Last Name*

Kaiser Facility* -----

Dept.*

Title (RN, NP, RT)* -----

Status (FT, PT, PTQ-260)* -----

Personal Email *(non-KP)

Phone#*

Alternate Phone #

Best time(s) to contact

Mailing Address *

City *

State/Zip *

I'm submitting this form on behalf of *myself ☐ another person* ☐

Indicate Contract Section(s) or Principles of Responsibility (POR) violated, (if known)

When did the incident occur?(be as specific as possible with **date/time**)*

Where did the incident occur? (location)*

Who was involved (name/title(s), witnesses – include contact number(s))

What is the problem? Describe the incident which led to your concern (attach supporting documents or separate statements if more space is needed.

If you were given an explanation of what happened, tell us **who** gave you the explanation, and **what** the explanation was.

Please describe any attempts you have made to resolve this problem. Include names of individuals/depts/agencies and dates, and give a brief description of each result.

Please state clearly what resolution you are seeking and what you would like HNHP to do for you.*

Additional Information

Office use only Date Received _____Log #_____Assigned to_____

Date of Response to member _____Joint Discovery Date _____

Grievance Filed Y/N_____(Indiv/Class) ULP Filed _____Other _____