# Complaint Form

Revised 06/2024

This form may be used to file a complaint with the Oregon Medical Board regarding care provided by Medical Doctors, Doctors of Osteopathic Medicine, Doctors of Podiatric Medicine, Physician Associates, and Acupuncturists. *The OMB does not have jurisdiction over nurses, nurse practitioners, medical associates, medical office staff, hospitals, or clinics.*

***A complaint may also be filed without using this form by submitting a detailed written letter to the Board summarizing your complaint.***

If you choose to use this Complaint Form, please complete the following information and attach photocopies of any documents, including medical records if available, that are pertinent to your complaint. State in detail all facts which you believe justify your complaint. Use additional paper as necessary.

**Complainant Information (your information):**

First Name | Middle Name | Last Name

Street Address | City, State, Zip Code

Home Phone | Cell Phone | Date of Birth

Email Address | Relationship to Patient

**Patient Information (if different from above):**

First Name | Middle Name | Last Name

Street Address | City, State, Zip Code

Home Phone | Cell Phone | Fax | Date of Birth

Email Address

**Complaint Against:**

☐ Medical Doctor ☐ Doctor of Osteopathic Medicine ☐ Doctor of Podiatric Medicine ☐ Physician Associate ☐ Acupuncturist

Provider First Name | Provider Middle Name | Provider Last Name

Street Address | City, State, Zip Code

License Number (if known) | Office Phone | Email Address (if known)

# Complaint Form

Revised 06/2024

**Specific Information about your Complaint:**

a) What are the dates the provider in question cared for you/patient?

b) Have you contacted the provider directly about your complaint? ☐ Yes ☐ No

If YES, what action, if any, was taken?

c) Did any other provider(s) treat you/patient after the alleged incident? ☐ Yes ☐ No

If YES, please specify names and address of other providers.

d) Have you/patient been treated at any hospitals or urgent care facilities related to this complaint? ☐ Yes ☐ No

If YES, please identify the facility name, address, and date of treatment.

e) Have you filed this complaint elsewhere? ☐ Yes ☐ No

If YES, where?

If YES, what action was or is being taken?

# Complaint Form

Revised 06/2024

**Please describe your complaint in detail below (use additional paper if necessary):**

**I certify that the above information is true to the best of my knowledge.**

Signature of Complainant

Date

To submit this complaint to the Board, please print this document and mail it to the Board at the following address:

**Oregon Medical Board**
**1500 SW 1st Ave, Suite 620**
**Portland, OR 97201**