



COMPLAINT FORM

OFFICE USE ONLY: Date received _____ Complaint number: _____ Reviewed _____

Please **type** or **print legibly** and return to the above address. Please include all relevant documentation.

PERSON REGISTERING COMPLAINT	
NAME	PHONE NUMBERS
ADDRESS	HOME ()
CITY STATE ZIP	BUSINESS () CELL ()
HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD? YES NO	

COMPLAINT REGISTERED AGAINST:
NAME _____ (Please use the full name of the PERSON against whom you are filing the complaint. PLEASE DO NOT USE the name of the facility or company.)
ADDRESS
CITY STATE ZIP
DAYTIME PHONE

DETAILS OF COMPLAINT

1. DATE OF INCIDENT _____

2. NATURE OF YOUR COMPLAINT. (Check all that apply.)

<input type="checkbox"/> Quality of care, competency	<input type="checkbox"/> Suspect insurance fraud
<input type="checkbox"/> Violation of the Board's Law and Rules	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Conviction having a direct bearing on license or practice	<input type="checkbox"/> Unethical or unprofessional conduct
<input type="checkbox"/> Inappropriate contact or conduct with a patient	<input type="checkbox"/> Allowing an unlicensed, incompetent or impaired individual to practice
<input type="checkbox"/> Practicing under a false name	<input type="checkbox"/> Breach of confidentiality
<input type="checkbox"/> Gross negligence in practice	<input type="checkbox"/> False, fraudulent or deceptive statement on any document in practice
<input type="checkbox"/> Physical or mental disability affecting ability or competency to practice	
<input type="checkbox"/> Other - Please describe below	

2. Have you communicated your concern to the practitioner or company? Yes No

If yes, on what date and by what means: _____

3. Did the practitioner or the company respond? Yes No

If yes, what was said or done?

4. Have you seen any other practitioner(s) prior to or after in connection with this complaint? Yes No
 (If yes, please provide name and address and phone number of the practitioner below):

5. STATE YOUR COMPLAINT: (Please provide a clear and concise description of the nature of your complaint, including dates of occurrence, the names and telephone numbers of witnesses and copies of documents pertinent to your complaint including contracts, photographs, x-rays, and patient records, insurance records, etc.)

(IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEETS OF PAPER)

I AFFIRM THE PRECEDING AND IT IS TRUE TO THE BEST OF MY INFORMATION AND BELIEF. I am filing this complaint to notify the Board of the activities of this practitioner so that it may be determined if discipline is warranted. I understand that a copy of this complaint may be provided to the licensee.

 SIGNATURE OF COMPLAINANT

 DATE

RELEASE OF MEDICAL RECORDS

(Failure to sign the release may result in a delay of the investigation of your complaint.)

I hereby authorize and direct you to release to the NDMIRTBE or its agents all records and information, including x-rays, of any treatment and/or consultation of NAME OF PATIENT _____ as may be requested by the Board or its agent. A copy of my signature on this release shall be authorization and direction to release such records and information as is appropriate to the investigation of the complaint. Only individuals directly involved in the complaint process will have access to these records. Copies of this authority may be utilized with the same effectiveness as an original. **If this complaint involves a minor, this release must be signed by the minor's parent or legal guardian, and authorizes the release of the minor's medical records to the North Dakota Medical Imaging and Radiation Board of Examiners and its agents for investigative purposes.**

I also hereby consent to the release of my identity and/or records to other state licensing boards and/or law enforcement agencies.

Date: _____ Signature: _____