North Dakota Medical Imaging and Radiation Therapy Board
PO Box 398 ▪ Bismarck, ND 58502 ▪ Phone 701-425-0861 ▪ Fax 701-224-9824
Web www.ndmirtboard.com ▪ Email info@ndmirtboard.com

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.)

____Quality of care, competency
____Violation of the Board's Law and Rules
____ Conviction having a direct bearing on license or practice
____Inappropriate contact or conduct with a patient
____Practicing under a false name
____Gross negligence in practice
____ Suspect insurance fraud
____ Substance abuse
____ Unethical or unprofessional conduct
____Allowing an unlicensed, incompetent or impaired individual to practice
____Breach of confidentiality
____False, fraudulent or deceptive statement on any document in practice
____Physical or mental disability affecting ability or competency to practice
____Other - Please describe below

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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?

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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):

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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.)

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(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: ____