Louisiana State Board of Medical Examiners

630 Camp Street, New Orleans, LA 70130
Phone: (504) 568-6820
Fax: (504) 568-5754
Web site: http://www.lsbme.la.gov

COMPLAINT FORM

1. Name of complainant: _____

2. Address and telephone number of complainant:

Address: _____ City: _____ State: _____ Zip: _____

Day phone #: _____ Evening Phone #: _____ Email: _____

3. Relationship of complainant to patient:_____

4. Name and Date of Birth of patient: Name:_____ Date of Birth:_____

5. Full name and address of practitioner about whom you are complaining (provide a separate complaint form for each practitioner or allied health professional about whom you wish to complain):

Name: _____

Address: _____, City: _____. State: _____ Zip: _____

Phone #: _____

Approximate dates of treatment: From: _____ To: _____

6. Nature of complaint (check all that apply)

- ☐ Poor medical care
- ☐ Rude or discourteous behavior
- ☐ Over utilization of testing
- ☐ Suspected impairment (drugs or other condition)
- ☐ Sexual misconduct
- ☐ Failure to release patient records
- ☐ Substance abuse
- ☐ Insurance fraud
- ☐ Poor communication skills or poor "bedside manner"
- ☐ Problem other than listed above

7. Please **attach** a clear and concise description of the nature of your complaint.

Complainant's Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE YOUR COMPLAINT INFORMATION

To Whom It May Concern:

I hereby give the Louisiana State Board of Medical Examiners permission to send a copy of my complaint to the practitioner listed below:

Licensee's Name: _____

Business Address: _____

City, State, Zip Code: _____

I further authorize the above named practitioner to release all information pertinent to this complaint to the Louisiana State Board of Medical Examiners.

Patient's Name (please print): _____

Complainant's Name: _____

Relationship to Patient: _____

Complainant's Signature: _____ Date: _____