DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND BOARD OF PHYSICIANS
4201 PATTERSON AVE. BALTIMORE, MD 21215
Phone (410)764-4777 FAX (410)358-1298 TDD FOR DISABLED
MD Relay Service
1-800-735-2258

COMPLAINT FORM

Please complete this form and return to:

Maryland Board of Physicians
INTAKE UNIT
4201 Patterson Avenue
Baltimore, MD 21215

If you have any questions, please call 410-764-2480 or 1-800-492-6836 ext.# 2480.

1. IDENTIFY THE TYPE OF HEALTH PROVIDER:

_____Physician
_____Radiographer
_____Nuclear Medical Technologist
_____Radiation Therapist
_____Polysomnographic Technologist
_____Naturopathic Doctor
_____Psychiatrist Assistant
_____Physician Assistant
_____Respiratory Care Practitioner
_____Radiologist Assistant
_____Athletic Trainer
_____Perfusionist

2. IDENTIFY THE HEALTH PROVIDER:

Full Name: _____
(Please Print)

Office Address:_____
(Street)

_____
(City) (State) (Zip Code)

Office Telephone: _____-_____-_____

3. PATIENT NAME:

Full Name: _____
(Please Print)

Home Address:_____
(Street)

_____
(City) (State) (Zip code)

Home Telephone: _____-_____-_____

Patient's Date of Birth: _____/_____/_____

Office Telephone: _____-_____-_____

4. **IDENTITY OF COMPLAINANT: The Board cannot guarantee anonymity. Information in the complaint may be shared with the practitioner/licensee. If you wish to remain anonymous, do not include information on the complaint form, envelope, e-mail or other materials that may reveal your identity.**

If the person making the complaint is not the patient, please provide the following information:

Full Name: _____
(Please Print)

Home Address:_____
(Street)

_____
(City) (State) (Zip code)

Home Telephone: _____-_____-_____

Office Telephone: _____-_____-_____

5. **Date patient was treated: _____/_____/_____**

6. **Pharmacy used by patient: _____**

7. **RELATIONSHIP OF COMPLAINANT TO PATIENT:**

_____ Patient _____ Spouse _____ Relative _____ No relation

8. **WHAT, IF ANY, ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH THE HEALTH PROVIDER?**

_____

_____

_____

9. **STATE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE KNOWLEDGE OF YOUR COMPLAINT, INCLUDING ANY OTHER HEALTH PROVIDERS.**

_____

_____

_____

The Maryland Board of Physicians (MBP) supports the Americans with Disabilities Act and will provide this complaint packet in an alternative format to facilitate effective communication with sensory impaired individuals. (For example, Braille, large print, audio tape.) If you need such accommodation, please notify the MBP ADA designee, Yemisi Koya, at 410-764-4777; Toll-free Number, 1-800-492-6836, or use the Maryland Relay Services TT/Voice number, 1-800-735-2258. If you have a complaint concerning the MBP's compliance with the ADA, please contact Ms. Koya.

10. NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL AS POSSIBLE, WHAT EVENT OR EVENTS LED TO THE FILING OF THIS COMPLAINT. INCLUDE THE DATES AND REASON FOR SEEING THE HEALTH PROVIDER IN YOUR DESCRIPTION.

ITEM 10. NATURE OF COMPLAINT, CONTINUED:

11. IF THE DIAGNOSIS AND TREATMENT THAT WAS RENDERED, WHICH IS THE SUBJECT OF THIS COMPLAINT, WAS PAID BY THIRD PARTY INSURER, IDENTIFY INSURER AND PATIENT'S INSURANCE IDENTIFICATION NUMBER.

Insurance Identification Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

12. LIST THE IDENTITY OF ANY PERSONS TO WHOM YOU HAVE MADE A SIMILAR

COMPLAINT, INDICATE WHEN THE COMPLAINT WAS MADE.

_____

_____

_____

_____

13. ATTACH COPIES OF ANY REPORTS, BILLS, INVOICES, DOCUMENTS, OR STUDIES SUPPORTING OR RELATING TO YOUR CLAIM.

Copies of Supporting Documents Attached: _____Yes _____No

14. I HEREBY ATTEST THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT I AM COMPETENT TO MAKE THESE STATEMENTS.

_____

Date of Complaint Signature of Complainant

15. RELEASE OF MEDICAL RECORDS

I hereby consent to the release to the Maryland Board of Physicians, or its designated investigating body, of medical reports and records related to this occurrence from any hospital, related institution, or physician, including the physician who is the subject of this complaint.

If the Maryland Board of Physicians determines that this complaint is a fee dispute, I consent to sending this complaint to the Consumer Protection Division of the Attorney General=s office for mediation.

_____(Check if Yes)

If block is not checked, this complaint will be dismissed if the Board finds no probable violation of the Maryland Medical Practice Act.

16. RELEASE OF ADDITIONAL INFORMATION

I hereby consent to the release of any reports, responses, or any other material that the Maryland Board of Physicians deems necessary from any health care provider who provided treatment to me whether or not this health care provider is mentioned in any part of this complaint.

_____

Date of Complaint Signature of Complainant

08/29/13, Revised 10/24/14, 03/20/15, 04/28/16