Mississippi State Board of Medical Licensure

Mail to: 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216
Fax: 601-987-6822 Phone: 601-987-3079

Complaint Form

The Mississippi State Board of Medical Licensure has jurisdiction over the following professionals: Medical Doctors (M.D.), Osteopathic Doctors (D.O.), Podiatrists (D.P.M.), Physician Assistants (P.A.), Radiology Assistants (R.A.) and Acupuncturists (L.Ac.s) If your complaint concerns other professions or health facilities, you should contact the appropriate regulatory/licensing agency. Contact information and internet websites for other Mississippi State Agencies are listed on the Official State Web Site of Mississippi; http://www.ms.gov/index.jsp.

Please Type or Print in Black Ink

Your Name (First, Middle, Last)			
Mailing Address			
City		State	Zip Code
Physical Address			
City		State	Zip Code
E-Mail Address			
Area Code ( )	Home Phone Number		Daytime Number? Y/N
Area Code ( )	Cell Phone Number		
Area Code ( )	Work Number		

Patient Information	
Patient Name (First, Middle, Last)	
	Date of Birth MM/DD/YYYY
Your Relationship to patient (If you are patient, indicate self)	

Contact Information:
If you have any questions, please Contact the Investigative Division of the Mississippi State Board of Medical Licensure at: 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216 Fax: (601) 987-6822 Tel: (601) 987-0229, or 0227 or 0231 or 0230.

Mail Forms: Mail completed forms, any revisions or additional information to:
MSBML/ Investigative Division - **COMPLAINT**, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216.
DO NOT EMAIL original signatures are required.

Complaint Against:

(First, Middle, Last Name)		
Practice Location Address		
Clinic/Hospital/Center Name		
Physical Address		
City	State	Zip Code

Check One: ☐ Physician (M.D.) ☐ Physician (D.O.) ☐ Podiatrist (D.P.M.) ☐ Physician Assistant (P.A.)

☐ Radiology Assistant (R.A.) ☐ Acupuncturist (L.Ac.s)

To assure this individual is currently licensed to practice in the State of Mississippi, search the database by selecting the Dr Search link on the agency's website. If you cannot locate the name on the website, or if you do not have access to a computer, please call 601-987-3079.

Nature of Complaint
Check all that apply:

_____ Malpractice

_____ Impairment (Drug, Alcohol, Mental, Physical)

_____ Prescribing (Excessive, Under, Diversion, Internet)

_____ Sexual Misconduct

_____ Failure to Transfer or provide medical records

_____ Substandard Care (Delay in treatment, mis-diagnosis, patient abandonment)

_____ Unprofessional Conduct (misleading advertising, arrest or conviction)

_____ Unlicensed practice

_____ Other _____

✱This Board does not have jurisdiction regarding fee or insurance disputes.

COMPLAINT INCIDENT DETAIL

Please attach any additional pages of information concerning this complaint. If you have any supporting documents, submit only copies and retain your original copies.

Complaint Against (Practitioner's Name): _____

Dates of Treatment _____ Did you discuss this complaint with this person? If yes, what was their response? _____

_____

_____

Did you obtain a second opinion? _____ If yes, who? (Name, Address, Phone Number, Date of Treatment):_____

_____

Have you contacted an attorney? (Name, Address, and Phone Number) _____

_____

List Names, Addresses, and Phone Numbers of all persons who were a witness to or have knowledge of your complaint:

Please describe the nature of the illness or condition for which the practitioner was utilized. Attach additional pages if necessary:

_____

_____

_____

_____

_____

_____

_____

COMPLAINT INCIDENT DETAIL
(Continue)

Please describe the facts and circumstances surrounding your complaint. Attach additional pages if necessary:

I hereby attest that the information provided in this complaint is true and correct to the best of my knowledge.

Signature of Complainant

Date

AUTHORIZATION TO RELEASE INFORMATION

I, _____

hereby authorize _____,

agents, representatives or employees to release to the Mississippi State Board of Medical Licensure, Suite 200-B, 1867 Crane Ridge Drive, Jackson, Mississippi 39216, all records or information concerning any treatment which I may have received and/or evaluation for any illness or condition, physical or mental. I request that this information be disclosed to the Mississippi State Board of Medical Licensure for whatever purpose which the Board may deem necessary.

Any entity or person to whom this release is presented by the Mississippi State Board of Medical Licensure is authorized to rely solely on a copy of this Release, thereby authorizing the Mississippi State Board of Medical Licensure to retain the original thereof on file.

_____ _____

Signature of Patient or Authorized Person (Please Submit Proof) Date

Patient Information

Patient Name (First, Middle, Last)

Mailing Address

City State Zip Code

Social Security Number | Date of Birth MM/DD/YYYY

Relationship to Patient

NOTE TO PROGRAM RECEIVING THIS INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR, PART 2) PROHIBITS YOU FROM MAKING FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR IS OTHERWISE PERMITTED BY SUCH REGULATIONS.