NORTH DAKOTA BOARD OF MEDICINE

COMPLAINT FORM

Today's Date

Name of Person Submitting This Complaint

Address of Person Submitting This Complaint:

Street Address

City | State | Zip

Daytime Phone # | Evening Phone #

Name of Physician/Physician Assistant About Whom You Are Complaining

Name of Patient Involved in the Incident Which Gives Rise to This Complaint

Place (Hospital/Clinic, etc.) Where the Incident Giving Rise to This Complaint Occurred

Date of the Incident Giving Rise to This Complaint

I hereby declare that all of the information I have provided with this form is true and correct.

Signature of Person Submitting This Complaint

Please describe the conduct about which you are complaining. It is important to be as specific as is reasonably possible. If you are in possession of medical records or other documents which support your allegations, you should attach copies of those items to this form.