COMPLAINT COMMITTEE OF THE SD BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

101 N. Main Ave Suite 301
Sioux Falls, SD 57104
(605) 367-7781

Complaint Questionnaire

Please complete the following information concerning your complaint. Please attach any photocopies of documents, including medical records if available, that are pertinent to your complaint. State in detail all facts which you believe justify your complaint. If possible, state whether the information is within your personal knowledge, and if not, the source or sources of the information. (PLEASE PRINT OR TYPE)

Name of Complainant: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell phone: _____

Email: _____

Additional Names: _____

You will receive acknowledge receipt of your complaint, if necessary we may contact you for additional information, and will notify you of a final decision. Please be aware that evaluation of a complaint, especially if it rises to the level of an investigation is a time consuming process.

Please attach any photocopies of documents, including medical records that are pertinent to your complaint. **Do not send your original documents.**

Please send this form (please do not fax) to:

SDBMOE-Complaint Committee
101 N Main Ave Suite 301
Sioux Falls, SD 57104

Complaint Against: (First and Last Name):

_____

Address: _____

_____

Phone: _____

Additional Information Required

What is the date that the practitioner cared for you? _____

Did any other individual(s) treat you after the alleged incident? _____

If so, please specify name(s) and address(es): _____

_____

_____

Were you an inpatient or outpatient of any health care institution during or after the alleged incident?

If so, please specify the name(s) and address(es): _____

_____

Have you contacted the practitioner about your complaint? _____

What action was taken? _____

_____

Have you filed this complaint elsewhere? _____

If so, please specify: _____

_____

What action was taken or is being taken? _____

_____

_____

Please attach any photocopies of documents, including medical records that are pertinent to your complaint. Do not send your original documents.

Please describe your complaint in detail (attach extra sheets if necessary)

PLEAST NOTE: We may forward this complaint to the practitioner in question. Your signed complaint may be a matter of public record.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I FURTHER STATE THAT I WILL VOLUNTARILY APPEAR AND TESTIFY TO THE FACTS IN THIS COMPLAINT IF CALLED UPON BY THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS.

SIGNATURE OF COMPLAINANT _____

DATE: _____