NEW YORK STATE DEPARTMENT OF HEALTH
Office of Professional Medical Conduct

Complaint Form

Please print and complete all sections of this form and mail to:
Office of Professional Medical Conduct
Central Intake Unit
433 River St., Suite 1000, Troy, NY, 12180-2299
(This form must be mailed and include an original signature)

All reports of misconduct are kept confidential and are protected from disclosure according to New York State Public Health Law, Sections 230(10)(a)(v) and 230(11)(a). Any person who reports or provides information to the Board for Professional Medical Conduct in good faith, and without malice, shall not be subject to an action for civil damages or other relief as the result of making the report according to Section 230(11)(b).

SEE ATTACHED INSTRUCTIONS BEFORE COMPLETING

INFORMATION ABOUT YOU

Name _____ _____ _____
(Last) (First) (MI)

Address _____ _____ _____ _____
(No. and Street) (City) (State) (Zip Code)

Telephone (____) _____ (____) _____
Day Evening

(PLEASE PROVIDE A NUMBER WHERE YOU CAN BE REACHED)

PHYSICIAN OR PHYSICIAN ASSISTANT

Name _____ _____ _____
(Last) (First) (MI)

Address _____ _____ _____ _____
(No. and Street) (City) (State) (Zip Code)

Telephone (____) _____

COMPLAINT

DESCRIBE YOUR COMPLAINT AS COMPLETELY AS YOU CAN. PLEASE SIGN AND DATE THE FORM.

Patient's Name _____ _____ _____
(Last) (First) (MI)

Date of Birth __ __ __ __ __ __ __ __
Month Day Year

When did this happen? _____

Where did this happen? _____

Have you filed a complaint with anyone else? ☐ Yes ☐ No

If yes, with whom? _____

Complaint Form

Names of Witness (es) _____ (Last Name) _____ (First Name) _____ (MI)

_____ (Last Name) _____ (First Name) _____ (MI)

Explain _____

Signature _____ Date _____