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 ______________________