

**WEST VIRGINIA BOARD OF OSTEOPATHY**  
**334 Penco Road**  
**Weirton WV 26062**

Phone (304) 723-4638

Fax (304) 723-6723

**Board Use Only**

**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 that 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 \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
\_\_\_\_\_ PHONE \_\_\_\_\_

COMPLAINT AGAINST \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
\_\_\_\_\_ PHONE \_\_\_\_\_

**ADDITIONAL INFORMATION REQUIRED:**

Specific complaint \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date that the practitioner cared for you? \_\_\_\_\_

Did any 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 after or during the alleged incident? \_\_\_\_\_  
If so please specify 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 or is being taken? \_\_\_\_\_

If necessary, do you consent to the release of your medical records?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, complete the attached record release.



**WEST VIRGINIA BOARD OF OSTEOPATHY**  
**334 Penco Road**  
**Weirton WV 26062**

Phone (304) 723-4638

Fax (304) 723-6723

**RECORDS RELEASE AUTHORIZATION**

I hereby authorize and request you to release my records to:

**WEST VIRGINIA BOARD OF OSTEOPATHY**  
**334 Penco Road**  
**Weirton WV 26062**

The complete history records in your possession, concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

**\*\*\*NOTARIZATION REQUIRED\*\*\***

Witness: \_\_\_\_\_

To: \_\_\_\_\_  
(Doctor or Hospital)

Address: \_\_\_\_\_  
\_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the  
County of \_\_\_\_\_, in the State of \_\_\_\_\_.

My commission expires: \_\_\_\_\_ (SEAL)

Signature: \_\_\_\_\_