STATE OF WEST VIRGINIA
BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street, Suite 402
Charleston, WV 25301

Phone: 304-558-6095
Fax: 304-558-6096

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.

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

PLEASE NOTE: In order to insure procedural due process, the complaint will be sent to licensee for his (her) response. ONCE COMPLETED YOUR SIGNED COMPLAINT IS 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 West Virginia Board of Osteopathic Medicine.

DATE_____ SIGNATURE OF COMPLAINANT_____

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RECORDS RELEASE AUTHORIZATION

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

WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street – Suite 402
Charleston, WV 25301

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

Name: _____ Date: _____

Birthdate: _____

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: _____