INSTRUCTION SHEET

• The Board licenses and regulates physicians and physician assistants (PA).

• Complaints filed against non-licensees (practices, general medical staff, chiropractors, optometrists, nurses, dentists, podiatrists, etc.) nursing homes or hospitals will be returned to you with the appropriate referral address.

• If possible, the complaint should be filed by the patient or the patient’s legal representative unless being submitted by another health care professional.

• A copy of your complaint will be provided to the Physician or PA identified in your complaint for a review and response to the Board.

• Enter the information requested in each section of the complaint form. A separate form is required for each Physician or PA complaint. You may make a copy of this form if additional forms are needed.

• Remember to make a copy of the information you submit to the Board as any materials you provide to the Board will not be returned.

• Please do not use STAPLES when you return your complaint form; paperclips only.

• Please review the enclosed brochure “A Consumer’s Guide” to understand what happens during the complaint review process.

• Generally once a complaint is submitted to the Board it cannot be withdrawn.

• If you have questions regarding how to fill out or submit your complaint form you may contact the Complaint Department via email or phone at (919) 326-1109 or 1-800 253-9653, ext. 501.
NAME OF PERSON MAKING COMPLAINT

Your FULL Name: ________________________________
( Mr.  Mrs.  Ms. )

Your Mailing Address: ______________________________________________________

Your Daytime Phone#: ______________________________________________________

Your EMAIL Address: ______________________________________________________

Patient’s FULL Name: ________________________________
(if different than complainant)

Patient’s DATE OF BIRTH: ________________________________

Your relationship to patient: ________________________________________________

Information about the PHYSICIAN OR PA you are reporting – only 1 name per form

(A complaint submitted in a hospital or practice name will be returned)

Physician or PA FULL Name: ________________________________________________

Physician or PA Address: _________________________________________________

Physician or PA Telephone #: ______________________________________________
STATEMENT OF YOUR COMPLAINT

Typically you will not be contacted by the Board unless clarification or additional information is needed so please provide a concise account of your major concern related to the Physician or PA listed on your complaint form. If you do not have sufficient space then you may attach a separate typed document. Please also answer the questions at the bottom of this page.

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1. **When** did this event occur? Please list specific dates of service.

________________________________________________________________________

2. **Where** did this event occur? Please provide full name of practice or hospital(s).

________________________________________________________________________

3. Have you contacted the **Physician or PA** about your concerns? If yes, what was the response?

________________________________________________________________________

4. What would you consider to be a **fair resolution** to your complaint? (The Board cannot assist with compensation).

________________________________________________________________________

5. How did you **hear** about the NC Medical Board? (circle one or list “other”)

________________________________________________________________________