Oregon
Theodore R. Kulongoski, Governor

Oregon Medical Board
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COMPLAINT FORM
Oregon Medical Board

This form may be used to file a complaint with the Oregon Medical Board regarding care provided by the following medical practitioners: Medical Doctors, Doctors of Osteopathic Medicine, Podiatrists, Physician Assistants, and Acupuncturists. ***A complaint may also be filed without using this form by submitting a detailed written letter to the Board summarizing your complaint.***

If you chose to use this Complaint Form, please complete the following information. Please attach any photocopies of documents, including medical records if available, that are pertinent to your complaint. State in detail all facts which you believe justify your complaint.

1) Name of Complainant:

First: _____ Middle _____ Last: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of birth _____ Phone: _____ Relationship to Patient _____

2) Name of Patient (if not complainant above):

First: _____ Middle _____ Last: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of birth _____ Phone: _____

3) Complaint Against:

☐ Medical Doctor ☐ Doctor of Osteopathic Medicine ☐ Podiatrist ☐ Physician Assistant ☐ Acupuncturist

Provider Name: First: _____ Middle _____ Last: _____

Address: _____ City: _____ State: _____ Zip:_____

License number (*if known*): _____ Phone: _____

4) Specific Information about your Complaint:

a. Please check all boxes that apply regarding the nature of your complaint:

- ☐ Substandard Care (e.g. Misdiagnosis, negligent treatment, delay in treatment, etc.)
- ☐ Prescribing Issues (e.g. excessive/under prescribing, internet, etc.)
- ☐ Sexual Misconduct/Boundary Violations (e.g. sexual contact, inappropriate touching, remarks, etc.)
- ☐ Unprofessional Conduct (e.g. breach of confidentiality, record alteration, fraud, misleading advertising, arrest or conviction)
- ☐ Office Practice (e.g. failure to provide medical records to patient, patient abandonment, etc.)
- ☐ Physician/provider impairment (e.g. drug, alcohol, mental, physical)
- ☐ Unlicensed provider or aiding/abetting unlicensed practice
- ☐ Other: _____

b. What are the dates that the provider in question cared for you/patient? _____

c. Have you contacted the provider directly about your complaint? _____
If so, what action (if any) was taken? _____

d. Did any other provider(s) treat you/patient after the alleged incident? ☐ Yes ☐ No
If YES, please specify names and address of other providers: _____

e. Have you/patient been treated at any hospitals or urgent care facilities related to this complaint?
☐ Yes ☐ No If YES, please identify the facility name and address as well as the date of treatment (use an extra sheet of paper if necessary): _____

f. Have you filed this complaint elsewhere? _____ If yes, where? _____

What action was or is being taken? _____

5) Please describe your complaint in detail below (use additional paper if necessary):

I certify that the above information is true to the best of my knowledge.

Signature of Complainant _____ Date _____

To submit this complaint to the Board, please ***print*** this document and ***mail*** it to the Board at the following address:

Oregon Medical Board
1500 SW 1st Ave, Ste 620
Portland, OR 97201