



Oregon Board of Naturopathic Examiners



COMPLAINT FORM

This form may be used to file a complaint against a person or entity that practices or purports to practice naturopathic medicine within the State of Oregon. You may include any additional documents, photographs, or other evidence to substantiate your complaint. If you choose not to use this form, you may submit a detailed written letter to communicate your complaint.

After receiving your complaint, the Board will initiate an investigation. Investigations are a judicious process, which often require collection and analysis of evidence. It is important that you provide as much detail and information as possible so that the investigation may progress in a timely manner.

There are five (5) sections on this form. Please fill out each section completely and accurately. If a particular section or question does not apply, indicate that in the appropriate box.

Section 1 - Complaint Information

Please provide the following information about you, the person making and filing this complaint.

Last Name:		First Name:		Middle Initial:	
Home Address:					
City:			State:		Zip:
Daytime Phone (include area code):		Ext:	Evening Phone (include area code):		Ext:
Date of Birth:		E-mail Address:			
Relationship to Patient:					

Section 2 - Patient Information

Please provide the following information about the patient. If you are the patient, leave this section blank.

Last Name:		First Name:		Middle Initial:	
Home Address:					
City:			State:		Zip:
Daytime Phone:		Ext:	Evening Phone:		Ext:
Date of Birth:		E-mail Address:			

Section 3 - Provider Informaiton

Please provide the following information about the medical provider whom this complaint is about.

Last Name:		First Name:		Middle Initial:
Clinic or Business Name:				
Address:				
City:		State:	Zip:	
E-mail or Web Site Address (if known):		Telephone:		Ext:

Section 4 - Complaint Details

Please provide specific information regarding the nature of this complaint.

Check all appropriate boxes next to applicable complaint summaries:

Substandard Care (e.g. Misdiagnosis, negligent treatment, delay in treatment, etc.)

Prescibing Issues (e.g. excessive/under prescribing, internet, etc.)

Sexual Misconduct/Boudary Violations (e.g. sexual contact, inappropriate touching, remarks, etc.)

Unprofessional Conduct (e.g. breach of confidentiality, record alteration, fraud, misleading advertising, arrest or conviction, etc.)

Office Practice (e.g. failure to provide medical records to patient, patient abandonment, etc.)

Physician Impairment (e.g. drug, alcohol, mental, physical)

Unlicensed Provider or Aiding/abetting Unlicensed Practice

Other: _____

What dates or period of time was treatment received? _____

Have you contacted the provider and attempted to resolve your concern or complaint directly?

Yes No

If yes, what was the outcome?

Did any other providers treat the patient after the alleged incident?

Yes No

If yes, please provide their name and contact information:

Has the patient received treatment from a hospital or urgent care facility after the alleged incident?

Yes No

If yes, please provide their name and contact information:

Have you filed a complaint related to the alleged incident with any other agency or organization?

Yes No

If yes, please provide their name and contact information:

Are you including additional documents or information with this complaint?

Yes No

If yes, please describe the items:

Will the patient provide consent for the Board or its investigative agent to obtain medical records related to this complaint?

Yes

If yes, please complete and include the "AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION" form.

Section 5 - Declaration and Affirmation

Please read this statement, then sign and date.

I, _____, declare and affirm under penalty of perjury that
(Print your full name)
the information contained herein is true and correct to the best of my knowledge.

Signature

Date

To submit this complaint to the Board, you may send this form by mail or telephone facsimile.

Oregon Board of Naturopathic Examiners
Attn: Investigations
800 NE Oregon St Ste 407
Portland OR 97232
Fax: 971-673-0226
Email: obne.investigator@state.or.us

For Official Use Only	Investigator:
Date Received by OBNE:	Complaint No:
Date Mailed by OBNE:	