Oregon Board of Medical Imaging

CONSUMER COMPLAINT FORM

CONFIDENTIAL

Please complete the entire form and forward to the board office at the address provided. Feel free to include any additional documents or information that you believe may be relevant to this complaint.

PLEASE PRINT OR TYPE

COMPLAINANT INFORMATION	
Name:	
Mailing Address:	
Hm. Phone:	**Other Phone:**
Email:	
If this complaint involves someone other than yourself, please provide the name and relationship:	

LICENSEE INFORMATION	
Name of Technologist:	
Name of Facility:	
Mailing Address:	

DETAILS OF COMPLAINT
Please provide specific information concerning your complaint, including the date(s) and place(s) where the incident(s) occurred and the names of any witnesses. Use an additional sheet if necessary.

Have you filed this concern with any other agency or organization? ☐ **Yes** ☐ **No** **If yes, please identify the agency or organization:**
List supporting documents filed with this complaint:
AFFIDAVIT & SIGNATURE
I declare and affirm under penalty of perjury that the matters set forth in this complaint are true and correct to the best of my knowledge, information and belief. Signature _____ Date _____

Return Completed Form And Supporting Documentation To:

Oregon Board of Medical Imaging
800 NE Oregon Street, Suite 1160A
Portland, OR 97232
Ph: 971-673-0215 / Fax: 971-673-0218
Email: Ed.Conlow@state.or.us

Please Retain A Copy Of This Complaint For Your Records.