Complaint Form

Revised 7/2015

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. *Please note: the Oregon Medical Board does not have jurisdiction over Nurses, Nurse Practitioners, Medical Assistants, or medical office staff.*

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. Use additional paper as necessary.

1) Name of Complainant (Your Name):

First: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Relationship to Patient:_____

Home Phone: _____ Cell Phone: _____ Fax: _____

E-mail Address: _____

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: _____

Complaint Form

Revised 7/2015

4) Specific Information about your Complaint:

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

b. Have you contacted the provider directly about your complaint? ◯ Yes ◯ No

If so, what action (if any) was taken?

c. Did any other provider(s) treat you/patient after the alleged incident? ◯ Yes ◯ No

If YES, please specify names and address of other providers:

d. 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

e. Have you filed this complaint elsewhere? ◯ Yes ◯ No

If yes, where?

What action was or is being taken?

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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, Suite 620
Portland, OR 97201