Print Form

Oregon Board of Medical Imaging

Consumer Complaint Form

** Confidential **

Case No. _____

"The mission of the Oregon Board of Medical Imaging is to promote, preserve and protect the public health, safety and welfare of Oregonians who are undergoing medical imaging studies performed by agency licensees for the purpose of medical diagnosis and therapy."

Fill Out Completely and Return Form to: **OBMI – 800 NE Oregon Street, Suite 1160A – Portland, OR 97232**
*** Phone: 971-673-0216 * Fax: 971-673-0218**

Complainant's Contact Information:

Last Name	First Name	Middle Name:
Mailing Address:		
City:	State:	Zip Code:
Telephone No:	Fax No:	
Email Address:		

If you want us to communicate with someone else, such as a family member, attorney, or another person representing you about this complaint, then please provide your representative's information below. Note: If you list someone else and sign this form, you allow us to communicate with and provide relevant information that is about you to that person.

Name of Representative:		
Address:		
City:	State:	Zip Code:
Telephone No:	Fax No:	
Email Address:		

Name of Technologist or Facility That This Complaint is Pertaining to:

Technologist /or/ Facility :		
Mailing Address If Available:		
City:	State:	Zip Code:
OMBI License No.	Phone:	

If complaint is concerning one of our licensees, what type of medical imaging modality do they work in?

- ☐ ***M.R.I. Technologist***
- ☐ ***Nuclear Medicine Technologist***
- ☐ ***Ultrasound Technologist (Sonography)***
- ☐ ***Radiation Therapist***
- ☐ ***Radiographer Technologist***
- ☐ ***Radiology Practitioner Assistant***
- ☐ ***Registered Radiologist Assistant***

Factual Details of Complaint:

*Please provide specific information concerning your complaint.
*Carefully list the following information:

- **Date(s)**
- **Location(s)** (Where the incident(s) occurred.)
- **Witness (s)** (If available.)

Details of Complaint: You can type as much as you need to inside the box below. Attach additional sheets to this form if necessary.

Declaration and Affirmation:

You must read the following statement, then sign and date it.

I, _____ , declare and affirm under penalty of perjury that the matters
(Print or Type Your Full Name)

set forth in this complaint are true and correct to the best of my knowledge, information and belief.

_____ _____
Signature Date:

This is a fillable form. You can type in any open field. To navigate to the next field press your "Tab" button on your keyboard.

Fax this form to: 971-673-0218 or Email it to: ed.conlow@state.or.us