Print Form

Oregon Board of Naturopathic Medicine

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.)
- ☐ 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, 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.

Please describe the incident in detail. Include as much information as possible, including the names and contact information for any witnesses. You may use additional pages if necessary.

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 Medicine
Attn: Investigations
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Portland OR 97232
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Email: obnm.investigator@state.or.us

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