



HEALTH LICENSING OFFICE
Board of Direct Entry Midwifery

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DIRECT ENTRY MIDWIFERY COMPLAINT FORM

If you are using any Apple product (Mac, iPad, iPhone), please download and use Adobe Reader before completing this form.

1. Midwife Information:

NAME OF BUSINESS OR BIRTH CENTER	
NAME OF MIDWIFE	MIDWIFE LICENSE NUMBER (if known)

2. Person Filing Complaint:

NAME		DATE	
MAILING ADDRESS			
CITY		STATE	ZIP
PHONE	BUSINESS PHONE	EMAIL	

ARE YOU A MANDATORY REPORTER? YES NO

3. Birth Mother Information:

NAME OF BIRTH MOTHER	MOTHER'S DATE OF BIRTH	MOTHER'S HEALTH RECORD NUMBER (if known)	
ADDRESS OF BIRTH MOTHER			
CITY		STATE	ZIP
PHONE	BUSINESS PHONE	EMAIL	

4. Baby and Birth Information:

NAME OF BABY	BABY'S DATE OF BIRTH	BABY'S HEALTH RECORD NUMBER (if known)	
PHYSICAL ADDRESS WHERE THE BABY WAS BORN			
CITY		STATE	ZIP
WAS BABY TRANSPORTED TO HOSPITAL? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, PLEASE INDICATE NAME OF HOSPITAL		
IF TRANSPORTED, PLEASE INDICATE THE ADDRESS OF THE HOSPITAL (if known)			
CITY		STATE	ZIP

Please continue on the next page...

5. Nature / Description of Complaint / Affected Person(s): (attach additional pages if necessary)

Please describe issues or concerns that you have with this midwife's practice, including details about the birth (if applicable), and possible violations that you think need to be investigated.

Complainant's Signature:

Date:

The Health Licensing Office has no authority to require licensees to refund money to their clients. The office only has authority to investigate and take action when violation of Oregon Revised Statutes or Oregon Administrative Rules is proven.