Complaint Form

Revised 9/2017

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, medical office staff, hospitals, or clinics.*

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: ____________________________

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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