Idaho State Board of Medicine

COMPLAINT FORM

Please mail your completed complaint form to:
Idaho State Board of Medicine
PO BOX 83720, Boise, ID 83720-0063

PLEASE NOTE: THIS IS **NOT** AN APPLICATION FOR MEDICAL MALPRACTICE PRE-LITIGATION SCREENING.
Do not use this form to file for Pre-litigation consideration of a personal injury claim for money damages.
Applications for Pre-litigation Screenings are available at bom.idaho.gov under the Pre-litigation option.

COMPLAINANT INFORMATION

PATIENT'S NAME: _____ Patient's Date of Birth: _____

YOUR NAME: _____ Relationship to Patient: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

TELEPHONE #: _____ EMAIL: _____

RESPONDENT INFORMATION

Please identify the Health Care Provider your complaint is about.
For any profession not listed below, please contact the Board at 208-327-7000 to learn where to file your complaint.

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathic Medicine (DO)
- ☐ Naturopathic Medical Doctor (NMD)
- ☐ Physician Assistant (PA)
- ☐ Dietician (DT)
- ☐ Athletic Trainer (AT)
- ☐ Respiratory Therapist (RT)
- ☐ Polysomnographer (PSG)

FIRST NAME: _____ LAST NAME: _____

BUSINESS ADDRESS: _____

CITY / STATE / ZIP: _____

TELEPHONE #: _____ FAX#: _____

NATURE OF COMPLAINT

DATE(S) OF INCIDENT OR CARE: _____

In the space below, please provide a factual account of what occurred, or your concerns about this provider. Attach additional sheets as needed.

Complaint submitted by: _____ Date: _____

Signature of Complainant

NOTIFICATION

You will be notified of the Idaho State Board of Medicine's (Board) receipt of your complaint. You may be requested to provide additional information and/or documentation supporting your complaint. Any materials (documents, photos, etc.) provided to the Board during the course of the investigation may not be returned.

When the Board conducts an investigation, it is handled in a confidential and discreet manner as required by state law. A request for confidentiality cannot be respected in accordance with fairness and procedural process.

The provider named in your complaint (Respondent) will also be notified and will be provided a copy of your complaint. The Respondent will be requested to answer and provide copies of relevant documents, including medical records.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any hospital, physician or other person who has any information regarding my medical care and treatment to release any and all medical records, reports and/or information to the Idaho State Board of Medicine or to such other representative of the Idaho State Board of Medicine as may be designated, for examination and for copying thereof, upon request for such records, reports or information for the specific purpose of addressing concerns relevant to my medical care and treatment.

I further authorize any hospital, physician or other person who has such information to consult with or discuss such information with any of the above entities or persons.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Medicine.

DATED this _____day of _____, 20____.

Signed: _____, Patient/Guardian

Printed Name: _____, Patient/Guardian