



Nevada State Board of Osteopathic Medicine

COMPLAINT FORM

Your Name: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Physician Named in Complaint: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Nature of Complaint: _____

Date(s) of Occurrence: _____

Treatment Received At (please include address if different than listed above):

☐ Physician's Office: _____

☐ Hospital: _____

☐ Other: _____

Did you obtain a second opinion from another physician? _____

Name of Physician: _____

Address: _____

Diagnosis: _____

NOTE: Type or neatly print your complaint on the attached Complaint Summary Page. Be as concise as possible. Make copies and attach any documents you have which support your allegation(s).

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Signature: _____ Date: _____

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