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: ___________________________________________________________

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).

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Page 1