Please print, complete all sections and return to:
Office of Professional Medical Conduct
433 River St., Suite 303, Troy, NY, 12180-2299
(This form will not be sent electronically.)

All reports of misconduct are kept confidential and are protected from disclosure according to New York State Public Health Law, Sections 230(10)(a)(v) and 230(11)(a). Any person who reports or provides information to the Board for Professional Medical Conduct in good faith, and without malice, shall not be subject to an action for civil damages or other relief as the result of making the report according to Section 230(11)(b).

--See Instructions before completing--

INFORMATION ABOUT YOU

(Last) (First) (MI)
Name_____ _____ __

(No. and Street) (City) (State) (Zip Code)
Address_____ _____ __ __ __ __ __ __ __

Telephone Day (____)_____ Evening (____)_____
(If you do not have a daytime telephone number, please provide a number where a message can be left for you during the day.)

PHYSICIAN OR PHYSICIAN ASSISTANT

(Last) (First) (MI)
Name_____ _____ ___

(No. and Street) (City) (State) (Zip Code)
Address_____ _____ __ __ __ __ __ __ __

Telephone (____)_____

COMPLAINT

Describe your complaint as completely as you can. Please sign and date the form.

(Last Name) (First Name) (MI)
Patient's Name_____ _____ __ __

(Mo) (Da) (Yr)
Date of Birth __ __ __ __ __ __

When did this happen?_____

Where did this happen?_____

Have you filed a complaint with anyone else? Yes_____ No _____

If yes, with whom?_____

(Last Name) (First Name) (MI)

Names of Witnesses _____ _____ __

_____ _____ __

Description_____

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

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_____

Signature_____Date_____

Questions or comments: opmc@health.state.ny.us
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