



BOARD OF REGISTRATION IN MEDICINE

200 Harvard Mill Square, Suite 330

Wakefield, Massachusetts 01880

(781) 876-8200

<http://www.massmedboard.org>

COMPLAINT INTAKE FORM FOR PHYSICIANS

The Board of Registration in Medicine licenses and regulates physicians and acupuncturists. Type or print legibly in ink. Do not write in the margins.

To facilitate the processing of this complaint, ensure that all documents are legible. If you are submitting copies of relevant documents to support your complaint, they should be in paper form only. You may include photographs, which cannot be returned. **Do not send objects, tapes, videos, CDs or X-rays.**

Additional information or materials attached

Yes

No

COMPLAINANT INFORMATION:

Your relationship to the patient (i.e. parent, self or spouse) _____

Gender: Female Male Date of Birth _____

Last Name First Name Middle Initial

Address Daytime Phone

City State Zip Code Alternate Phone

PATIENT INFORMATION:

Same as above:

Yes

No

Gender: Female Male Date of Birth _____

Last Name First Name Middle Initial

Address Daytime Phone

City State Zip Code Alternate Phone

PHYSICIAN INFORMATION: (Use separate form for each licensed physician)

Last Name First Name Middle Initial

Address Business Phone

City State Zip Code Specialty

MEDICAL TREATMENT INFORMATION:

How long has the patient been under this physician's care? _____

If the patient is deceased, provide the date of death. _____

Location of treatment: Office Practice Clinic Hospital Nursing Home Other _____

Treatment site (list if different than the address provided on page one in the physician information section)

Name of treatment facility			
Address		Daytime Phone	
City	State	Zip Code	Alternate Phone

ADDITIONAL HEALTHCARE PROVIDER INFORMATION:

Please list the names, addresses and types of other healthcare providers, i.e., physicians, dentists or chiropractors, who provided treatment that may relate to this complaint. (Use a separate sheet if necessary.)

Name			
Address		Daytime Phone	
City	State	Zip Code	Type of Provider

Name			
Address		Daytime Phone	
City	State	Zip Code	Type of Provider

ACKNOWLEDGEMENT

By signing and submitting this form, I acknowledge that the Board of Registration in Medicine may (1) refer my complaint to other appropriate law enforcement or regulatory authorities; and (2) may obtain medical records and other information relating to this complaint. In addition, I acknowledge that a copy of my complaint and all attachments may be forwarded to the physician. I further acknowledge that, if I am not the patient, the Board will not share the patient's confidential medical information with me without legal proof that I am authorized to receive such information.

I attest that the information provided by me is true, correct and complete to the best of my knowledge.

Complainant signature

Date

Printed name of Complainant

