

NORTH DAKOTA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT FORM

Today's Date

Name of Person Submitting This Complaint

Address of Person Submitting This Complaint:

Street Address

City

State

Zip

Daytime Phone #

Evening Phone #

Name of Physician/Physician Assistant About Whom You Are Complaining

Name of Patient Involved in the Incident Which Gives Rise to This Complaint

Place (Hospital/Clinic, etc.) Where the Incident Giving Rise to This Complaint Occurred

Date of the Incident Giving Rise to This Complaint

I hereby declare that all of the information I have provided with this form is true and correct.

Signature of Person Submitting This Complaint

