NEW YORK STATE DEPARTMENT OF HEALTH
Office of Professional Medical Conduct

# Complaint Form

**Please print clearly and complete all sections of this form and mail to:**

Office of Professional Medical Conduct
Central Intake Unit
Riverview Center
150 Broadway- Suite 355
Albany, NY 12204-2719

**(This from must include your original signature)**

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 on page 4 before completing this form.**

## INFORMATION ABOUT YOU

Name _____
Last First MI

Address _____
House number & Street Name City State Zip Code

Telephone ( _____ ) _____ – _____ ( _____ ) _____ – _____
Day time number Evening Number

## YOUR COMPLAINT REGARDING A PHYSICIAN OR PHYSICIAN ASSISTANT

Physician/Physician Assistant Name _____
Last First MI

Address _____
Number & Street Name City State Zip Code

Telephone ( _____ ) _____ – _____

## INFORMATION ABOUT THE PATIENT(S)

** You may add additional patient names on a separate sheet of paper.

Patient(s) Name _____
Last First MI

Date of Birth _____ _____ / _____ _____ / _____ _____ _____ _____
Month Day Year

## DETAILS OF YOUR COMPLAINT

**Describe your complaint as completely as possible. Please sign and date form.**

When did this happen? _____

Where did this happen? _____

_____

Have you filed a Complaint with anyone else? ☐ Yes ☐ No

If Yes, with whom? _____

_____

Were there any witnesses?
You may add additional witness names on a separate sheet of paper.

Witness Name _____
Last First Name MI

Witness Name _____
Last First Name MI

## EXPLAIN YOUR COMPLAINT

_____

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_____

_____

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## EXPLAIN YOUR COMPLAINT

Signature

Date

## INSTRUCTIONS FOR COMPLETING COMPLAINT FORM

To file a complaint about a physician (M.D. or D.O.), Physician Assistant or Specialist Assistant licensed to practice medicine by the State of New York, please complete this form and mail the original to:

NYS Department of Health
Office of Professional Medical Conduct
Riverview Center 150 Broadway, Suite 355
Albany, New York 12204-2719

If you have any questions regarding the filling out of this form, please contact OPMC at: (800) 663-6114 or (518) 402-0836.

Trained staff will review the information you submit. OPMC will investigate all matters of possible professional misconduct. If your complaint requires the attention of another office, it will be sent to the office authorized to address your concerns.

To help us review your complaint, please do the following:

- Type or print clearly in ink.
- Describe your complaint completely.
- Include the names of any witnesses.
- Include the names of other agencies with whom you filed a complaint.
- Attach additional pages if necessary.
- Attach copies of supporting documents. Do not send originals.
- Sign and date the form.