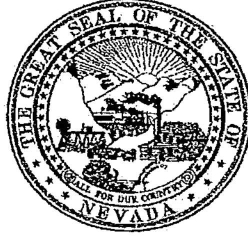

Nevada State Board of Osteopathic Medicine

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).

COMPLAINT SUMMARY

Signature: ______________________ Date: ______________________

2275 Corporate Circle – Suite 210 – Henderson, NV 89074
(702) 732-2147 – Fax (702) 732-2079