COMPLAINT FORM

PLEASE NOTE: THIS IS **NOT** AN APPLICATION FOR
MEDICAL MALPRACTICE PRELITIGATION SCREENING.
Do not use this form if you wish prelitigation consideration of a personal injury claim for money damages. Applications for Prelitigation Screenings are available at bom.idaho.gov under the Prelitigation option.

Please mail your printed or typed complaint to:
Idaho State Board of Medicine, PO Box 83720, Boise, Idaho, 83720-0058.
EXPRESS MAIL: 1755 Westgate Dr., Suite 140, Boise, Idaho, 83704.

I. Name of Complainant: _____

Address: _____

City/State/Zip: _____

Telephone Home: ___, _____Business: ___, _____Cell: ___, _____FAX: ___, _____

II. Identifying information about Health Care Provider whom the complaint is being made: (Please check appropriate box.)

☐ MD/DO
☐ PHYSICIAN ASSISTANT
☐ Other (SPECIFY)_____

Name of Health Care Provider: _____

Business Address: _____

City/State/Zip: _____

Business Telephone: ____, _____ Business FAX: ____, _____

Date(s) of Incident or Care_____
(Please provide the approximate date(s) you were provided care and/or the date of the incident.)

III. Nature of Complaint: Please provide a factual account of what occurred or your concerns about the care that was provided. Attach additional sheets as needed.

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IV. Is this Health Care Provider your primary health care provider? Yes ☐ No ☐

Were you referred to this Health Care Provider? Yes ☐ No ☐

V. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any hospital, physician or other person who has any information regarding my medical care and treatment to release any and all medical records, reports and/or information to the Idaho State Board of Medicine or to such other representative of the Idaho State Board of Medicine as may be designated, for examination and for copying thereof, upon request for such records, reports or information for the specific purpose of addressing concerns relevant to my medical care and treatment.

I further authorize any hospital, physician or other person who has such information to consult with or discuss such information with any of the above entities or persons.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Medicine.

DATED this ____ day of _____, 20___.

Signed: _____, Complainant

Printed Name: _____, Complainant

A SUBMITTED COMPLAINT FORM WITHOUT A SIGNATURE IS NOT ACCEPTED.

VI. NOTIFICATION

You will be notified of the Idaho State Board of Medicine's (Board) receipt of your complaint. You may be requested to provide additional information and/or documentation supporting your complaint. When the Board conducts an investigation, it is handled in a confidential and discrete manner as required by state law. A request for confidentiality cannot be respected in accordance with fairness and procedural process.

The provider named in your complaint (Respondent) will also be notified and will be provided a copy of your complaint. The Respondent will be requested to answer and provide copies of relevant documents, including medical records. Both you and the Respondent will be updated every 45-60 days until the matter is resolved.