New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
140 East Front Street, 2nd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Complaint Process

Please be assured that the allegations contained in your complaint will be fully reviewed. Because of the complex nature and number of complaints received by the Board of Medical Examiners, we cannot give you any specific date by which that review will be completed. To properly evaluate a complaint, the Board will need to obtain a response from the physician first. Thereafter, an investigation may be necessary. We may also need to obtain additional information from you. Your cooperation, patience and understanding are appreciated.

If you have not received a response an acknowledgement of your complaint from the Board within 60 days, you may contact the office by phone at (609) 826-7100 or by E-mail at: bmepatientadvocate@dca.lps.state.nj.us.

Please recognize that the Board has jurisdiction to take action against licensees only if their conduct violates the Medical Practice Act. Very often patients may be dissatisfied with the care that they have received, but the physician's conduct does not violate any specific statute or rule and so cannot be the basis for the imposition of discipline. You should also be aware that even if the Board determines that the statutory threshold for discipline has not been met, a patient who has been harmed may still be able to pursue a private cause of action, if a lawsuit is filed within the time allowed by law. If you believe that you may have a private cause of action, you should consult with an attorney to assure that your rights are protected.

While we cannot tell you when the Board's inquiry may be completed, we will advise you in writing when a final determination has been made. Thank you for bringing this matter to the attention of the Board. We hope to be able to address your concerns as soon as possible.

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Complaint Form

Please print clearly.

Please be advised that this complaint form, along with any documents you may have appended to the form, will be handled confidentially throughout the time that the Board investigates the allegations you have made. The document(s) will thereafter continue to be considered confidential if the Board concludes that there is no cause for action against the physician about whom you have complained. If the Attorney General determines that an enforcement action should be initiated, the document(s) you have supplied may be needed as evidence, and you may need to testify.

If a disciplinary action is taken against the physician about whom you have complained, based in part or in whole upon your complaint, then your complaint will be considered to be a "government record" and may be disclosed in response to a request made pursuant to the Open Public Records Act (OPRA). However, records relating to an individuals medical, psychiatric or psychological history, diagnosis, treatment or evaluation are not "government records" subject to public access pursuant to OPRA, and accordingly, references to your name and other identifying information may be removed, if deemed necessary, from any documents produced pursuant to an OPRA request.

Consumer Information

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

HOME TELEPHONE NUMBER: _____
(include area code)

WORK TELEPHONE NUMBER: _____
(include area code)

FAX NUMBER: _____

E-MAIL ADDRESS: _____

DATE: _____

Complaint Reported Against

NAME: _____

BUSINESS NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: _____
(include area code)

TITLE: _____

LICENSE NUMBER (IF KNOWN): _____

DATES OF TREATMENT/SERVICE:

FROM: _____ TO: _____

1. What is the relationship between the complainant and the consumer or patient?

   - ☐ Self
   - ☐ Parent
   - ☐ Friend
   - ☐ Legal Guardian
   - ☐ Spouse
   - ☐ Son/Daughter
   - ☐ Brother/Sister
   - ☐ Other (please specify) _____

2. Please provide the following information about the consumer or patient if he or she is someone other than the complainant.

   Name: _____ Date of birth: _____
   Month Day Year

   Address: _____
   Street address City State ZIP code

   Home telephone number: _____ Work telephone number: _____
   (include area code) (include area code)

3. Please provide the following information about any other practitioner or licensee involved in the matter about which you are filing a complaint.

   Name: _____

   Title: _____ License number: _____

   Address: _____
   Street address City State ZIP code

   Telephone number: _____
   (include area code)

   Name: _____

   Title: _____ License number: _____

   Address: _____
   Street address City State ZIP code

   Telephone number: _____
   (include area code)

4. Please provide the following about anyone who was a witness to the matter about which you are filing a complaint.

   Name: _____

   Address: _____
   Street address City State ZIP code

   Daytime telephone number: _____ Evening telephone number: _____
   (include area code) (include area code)

   Name: _____

   Address: _____
   Street address City State ZIP code

   Daytime telephone number: _____ Evening telephone number: _____
   (include area code) (include area code)

5. What is the nature of the complaint? *(Please check all that apply and provide any additional comments on a separate sheet of paper.)*

   ☐ Administrative/Recordkeeping ☐ Advertising ☐ Fees/Billing Practices
   ☐ Fraud ☐ Incompetence ☐ Insurance Fraud
   ☐ Professional/Occupational Misconduct ☐ Sexual Misconduct ☐ Substance Abuse/Impairment
   ☐ Unlicensed Practice ☐ Briefly explain the problem if it is not listed above: _____

   _____

6. Please describe the facts of your complaint in the order in which they happened. Please print clearly. You may use additional sheets of paper if they are needed.

_____

_____

_____

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7. Please describe any action taken to resolve this matter prior to contacting the Board. Please print clearly. You may use additional sheets of paper if they are needed.

_____

_____

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_____

All complaints must be accompanied by **readable copies** (NO ORIGINALS) of any complaint-related contracts, bills, receipts, canceled checks, correspondence or any other documents you feel are related to your complaint.

8. I certify that the statements made by me in this complaint are true and any documents attached are true copies. I am aware that if any statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature* Date

Return to:

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, NJ 08625

* This certification must be signed by the person who has completed this form.