Commonwealth of Massachusetts
Board of Registration in Medicine

COMPLAINT FORM

Return this form to: Consumer Protection Coordinator
Board of Registration in Medicine
178 Albion Street, Suite 330
Wakefield, MA 01880
Fax: (781) 876-8381

Please type or print legibly in ink. You may use the attached lined page to explain your complaint or attach your own paper to this form. Any additional information you would like to submit with your complaint must be in paper or electronic form and will not be returned. Do not send objects, tapes, or X-rays. If you have any questions, please call our Consumer Protection Unit at (781) 876-8200.

PHYSICIAN INFORMATION (*one physician for each Complaint Form*)

last name _____ first name _____ middle initial _____

street address _____ city _____ state _____ zip code _____

physician's medical specialty: _____ telephone number: _____

PATIENT INFORMATION

☐ male
☐ female

last name _____ first name _____ middle initial _____

street address _____ city _____ state _____ zip code _____

date of birth: _____ daytime telephone number: _____

location of treatment: ☐ Office ☐ Hospital ☐ Nursing Home ☐ Clinic ☐ Other _____

date(s) the incident(s) described in the complaint happened: _____

length of time the patient has been under the physician's care: _____

COMPLAINANT INFORMATION (*Complete **ONLY** if different from the patient information*)

NOTE: *The Board will not communicate the patient's confidential medical information to you without legal proof that you are authorized to receive the information.*

☐ male
☐ female

last name _____ first name _____ middle initial _____

street address _____ city _____ state _____ zip code _____

your relationship to the patient: _____ daytime telephone number: _____

ACKNOWLEDGEMENT

I acknowledge that, by submitting this complaint and signing this form, the Board of Registration in Medicine may (1) obtain medical records and other information relating to this complaint; and/or (2) refer my complaint to other appropriate regulatory or law enforcement authorities. I understand that the Board may provide a copy of my complaint and all attachments to the physician.

Complainant's signature _____ Date _____

revised 8/25/2011

Physician's Name:_____ Complainant's Name:_____

Briefly describe your complaint