Massachusetts Department of Public Health
Bureau of Health Professions Licensure

The Bureau of Health Professions Licensure (BHPL) investigates complaints and concerns regarding licensed professionals (licensees) on behalf of the Boards of Registration (Boards) that license Community Health Workers, Dental Assistants, Dentists, Dentistry Limited Licenses, Dental Hygienists, Dentistry Faculty Licenses, Provisional Genetic Counselors, Genetic Counselors, Advanced Practice Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Home Administrators in Training, Nursing Home Administrators, Perfusionists, Provisional Perfusionists, Pharmacy Retail Drug Store Permits, Nuclear Pharmacists, Nuclear Pharmacies, Nuclear Pharmacists, Pharmacists, Pharmacy Non-Resident Outsourcing Facilities, Pharmacy Interns, Pharmacy Technicians, Pharmacy Technician Trainees, Pharmacy Resident Outsourcing Facilities, Pharmacy Wholesale Distributor Permits, Physician Assistant Temporary Practice Certification, Physician Assistants, Respiratory Care Limited Permits, and Respiratory Therapists.

When information from a complaint investigation indicates that a licensee has violated a law or regulation relating to the particular profession, the licensing board may take administrative action against the licensee, ranging from issuing an advisory letter, requiring a licensee to take remedial education, or discipline of the individual's license to practice, e.g., stayed probation, reprimand, remedial education, probation, censure, suspension, and revocation. Each Board has its own regulations and practices related to discipline.

The HPL and the Boards of Registration **cannot** represent you in civil matters in a court of law or other tribunal to recover fees paid or to seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

ISSUES THAT ARE NOT WITHIN THE AUTHORITY OF THE HPL OR THE BOARDS OF REGISTRATION

- Fee disputes, such as payment for broken or missed appointments
- Billing disputes, such as the amount a licensee charges for services
- Personality conflicts

COMPLAINT FORM INSTRUCTIONS

- To file a complaint, you must submit a legible, signed and dated complaint that identifies the person or entity who is the subject of your complaint.
- If your complaint is about treatment you received, treatment or medical records are required to process your complaint. The signature of the patient or legal guardian to the *Authorization for Release of Records and Referral of Complaint* section is necessary.
- Use a separate form for each person or entity against whom you wish to file a complaint.
- Be **specific** in your complaint description, and include copies of pertinent medical records, correspondence, contracts and any other documents that support your complaint.
- HPL will send written notification of any action on your complaint.
- If the allegations contained in your complaint are determined to be possible violations of applicable laws and/or regulations, a complaint will be opened for investigation.
- If your complaint is opened and assigned for investigation, a copy of the complaint will be provided to the health care licensee or entity.
- HPL may, in its discretion, investigate an anonymous complaint if the complaint is in writing; if the complaint allegations constitute violations of law or regulations warranting Board action; if preliminary inquiry reveals sufficient information to determine that the allegations may be true; and if proving the allegations does not require the identification and/or testimony of the person filing the complaint.

Bureau of Health Professions Licensure
250 Washington Street, 3rd floor, Boston, MA. 02108
PH: (617)973-0865 FAX: (617)973-0985 TTY: (617) 973-0988

DPH Date Rec'd (stamp)

PHYSICIAN ASSISTANT COMPLAINT FORM

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF HEALTH PROFESSIONS LICENSURE
TEL (617) 973 – 0865 FAX (617) 973-0985 TTY (617) 973-0988
http://www.mass.gov/dph/boards/

DPH USE ONLY:
Entered into Database (date) _____/_____/_____ Complaint # _____ Initials _____

Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.

COMPLAINANT

☐Mr.
☐Mrs.
☐Ms. _____ _____ _____
Your Last Name Your First Name Patient's Name (If different)

Your Address: _____ _____ _____ _____
Street City State Zip

Patient Address: _____ _____ _____ _____
(If different) Street City State Zip

Your Primary Phone number: ( ) Your Secondary Phone number: ( ) Your Email:

LICENSEE

☐ PHYSICIAN ASSISTANT ☐ TEMPORARY PRACTICE CERTIFICATION

_____ _____ _____
Last Name First Name Lic # (if known)

Employer Name: _____ Phone #:_____

Employer Address: _____ _____ _____ _____
Street City State Zip

COMPLAINT DESCRIPTION

NATURE OF COMPLAINT

☐ Medication error
☐ Patient abandonment/neglect
☐ Quality of care provided
☐ Impairment
☐ Unlicensed practice
☐ Fraud
☐ Practice beyond the scope of practice
☐ Drug diversion
☐ Criminal conviction/conduct
☐ Other (specify)

DATE(S) OF INCIDENT(S): _____

DETAILS OF COMPLAINT Clearly describe the incidents leading up to your complaint. If applicable, **attach copies** of documents such as witness statements, medical records, copies of prescriptions, photographs, etc. that support your statements. DO NOT SEND ORIGINALS. Attach extra paper as needed to complete this section.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COMPLAINT DETAILS

Have you discussed this matter with the licensee, the licensee's office or facility? ☐ yes ☐ no

If yes, name and phone number of person contacted: _____

Date of contact: _____ How was contact made? (phone, e-mail, letter, in person) _____

Result of contact: _____

_____

_____

Witness name(s) and telephone number(s) (if applicable)_____

Have you filed this complaint with any other state or federal agencies? _____ If yes, identify and explain

_____

_____

Are you willing to testify regarding this matter at a formal hearing? ☐ Yes, I am willing. ☐ No, I am not willing.

AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature on this form, or photocopy thereof, authorizes the Department of Public Health Bureau of Health Professions Licensure to: (1) receive copies of all my health records relating to my complaint; (2) to share the complaint and all records collected by the Bureau of Health Professions Licensure during the investigation of my complaint with the licensee for the licensee's use in responding to the allegations in this complaint; and (3) to refer my complaint to other regulatory and/or law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis.

The act of filing a complaint and its receipt and/or investigation by DPH does not mean that disciplinary action will be taken against the licensee.

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of **Date**
☐**Patient or**
☐**Legal Representative**
(attach documentation)

Mail this form to:
Department of Public Health
Bureau of Health Professions Licensure
Attn: Office of Public Protection
250 Washington Street, 3rd Floor
Boston, MA 02108

DPH USE ONLY:

_____ _____

Signature of Executive Director or Designated Board Representative **Date**