Massachusetts Department of Public Health
Bureau of Health Professions Licensure

The Bureau of Health Professions Licensure (HPL) investigates complaints and concerns regarding licensed professionals (licensees) on behalf of the Boards of Registration (Boards) that license registered Nurses, Licensed Practical Nurses, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Certified Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Clinical Nurse Specialists, Dentists, Dental Hygienists, and Dental Assistants, Pharmacists, Pharmacy Interns and Technicians and Pharmacies, Nursing Home Administrators, Physician Assistants, Respiratory Therapists, Perfusionists and Genetic Counselors.

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
239 Causeway Street, 5th floor, Boston, MA. 02114
PH: (617)973-0865 FAX: (617)973-0985 TTY: (617) 973-0988

DPH Date Rec'd (stamp)

DENTAL 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 Business Name: _____
(if applicable)

Business Address: _____ _____ _____ _____

Street | City | State | Zip

Your Address: _____ _____ _____ _____

Street | City | State | Zip

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

LICENSEE

DO NOT LIST A DENTAL CLINIC OR DENTAL CENTER ON THIS LINE

☐DENTIST
☐DENTAL HYGIENIST
☐DENTAL ASSISTANT

_____ _____ _____

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

Licensee's Business Name: _____

Business Address: _____ _____ _____ _____ _____

Street | City | State | Zip | Phone

COMPLAINT DETAILS

PREVIOUS DENTIST (if applicable) _____

Name

_____ _____

Street and City Address | Phone

SUBSEQUENT DENTIST* (if applicable) _____

Name

_____ _____

Street and City Address | Phone

* Attach report from subsequent dentist (if available).

Have you discussed this matter with the dentist/hygienist/dental assistant or anyone in the licensee's office? ☐ yes ☐ no

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, explain_____

_____

If this complaint is against a person or entity licensed by the Dental Board, **are you willing to testify** in person regarding this matter at a formal hearing? ☐ Yes, I am willing. ☐ No, I am not willing.

What action by the Board would address your complaint? _____

COMPLAINT DESCRIPTION

NATURE OF COMPLAINT:

☐ Misdiagnosis of condition	☐ Inappropriate prescribing	☐ Impairment
☐ Patient abandonment/neglect	☐ Fraud	☐ Unlicensed practice
☐ Inferior Treatment - quality of care provided	☐ Business practice Issues	☐ Other (specify)
☐ Unable to obtain dental records or x-rays		

DATE(S) OF INCIDENT(S): _____

DETAILS OF COMPLAINT: Clearly describe the incident(s) leading up to your complaint. If applicable, **attach copies** of documents such as medical and/or dental records, photographs, bills, insurance statements, cancelled checks, correspondence, prescriptions, witness statements, etc. that support your statements. DO NOT SEND ORIGINALS. Attach extra paper as needed to complete this section.

_____

_____

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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
☐**Patient or**
☐**Legal Representative**
(attach documentation)

Date

Mail this form to:
Department of Public Health
Bureau of Health Professions Licensure
Attn: Office of Public Protection
239 Causeway Street, 5th Floor
Boston, MA 02114

DPH USE ONLY:

_____ _____

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