

DEPARTMENT OF HEALTH  
**MARYLAND BOARD OF PHYSICIANS**

4201 PATTERSON AVE. BALTIMORE, MD 21215

Phone (410)764-4777

FAX (410)358-2252

TDD FOR DISABLED MD Relay Service 1-800-735-2258

**COMPLAINT FORM**

Please complete this form and return to:

**Maryland Board of Physicians**  
**INTAKE UNIT**  
**4201 Patterson Avenue**  
**Baltimore, MD 21215**

If you have any questions, please call 410-764-2480 or 1-800-492-6836 ext.# 2480.

**1. IDENTIFY THE TYPE OF HEALTH PROVIDER:**

- |  |  |
|--|--|
| <input type="checkbox"/> Physician                     | <input type="checkbox"/> Psychiatrist Assistant        |
| <input type="checkbox"/> Radiographer                  | <input type="checkbox"/> Physician Assistant           |
| <input type="checkbox"/> Nuclear Medical Technologist  | <input type="checkbox"/> Respiratory Care Practitioner |
| <input type="checkbox"/> Radiation Therapist           | <input type="checkbox"/> Radiologist Assistant         |
| <input type="checkbox"/> Polysomnographic Technologist | <input type="checkbox"/> Athletic Trainer              |
| <input type="checkbox"/> Naturopathic Doctor           | <input type="checkbox"/> Perfusionist                  |

**2. IDENTIFY THE HEALTH PROVIDER:**

Full Name: \_\_\_\_\_  
(Please Print)

Office Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**3. PATIENT NAME:**

Full Name: \_\_\_\_\_  
(Please Print)

Home Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip code)

Home Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**4. IDENTITY OF COMPLAINANT: The Board cannot guarantee anonymity. Information in the complaint may be shared with the practitioner/licensee. If you wish to remain anonymous, do not include information on the complaint form, envelope, e-mail or other materials that may reveal your identity.**

If the person making the complaint is not the patient, please provide the following information:

Full Name: \_\_\_\_\_  
(Please Print)

Home Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip code)

Home Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**5. Date patient was treated:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**6. Pharmacy used by patient:** \_\_\_\_\_

**7. RELATIONSHIP OF COMPLAINANT TO PATIENT:**

Patient     Spouse     Relative     No relation

**8. WHAT, IF ANY, ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH THE HEALTH PROVIDER?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. STATE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE KNOWLEDGE OF YOUR COMPLAINT, INCLUDING ANY OTHER HEALTH PROVIDERS.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Maryland Board of Physicians (MBP) supports the Americans with Disabilities Act and will provide this complaint packet in an alternative format to facilitate effective communication with sensory impaired individuals. (For example, Braille, large print, audio tape.) If you need such accommodation, please notify the MBP ADA designee, Rhonda Anderson, at 410-764-4777; Toll-free Number, 1-800-492-6836, or use the Maryland Relay Services TT/Voice number, 1-800-735-2258. If you have a complaint concerning the MBP's compliance with the ADA, please contact Ms. Anderson.

**10. NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL AS POSSIBLE, WHAT EVENT OR EVENTS LED TO THE FILING OF THIS COMPLAINT. INCLUDE THE DATES AND REASON FOR SEEING THE HEALTH PROVIDER IN YOUR DESCRIPTION.**

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**12. LIST THE IDENTITY OF ANY PERSONS TO WHOM YOU HAVE MADE A SIMILAR COMPLAINT, INDICATE WHEN THE COMPLAINT WAS MADE.**

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**13. ATTACH COPIES OF ANY REPORTS, BILLS, INVOICES, DOCUMENTS, OR STUDIES SUPPORTING OR RELATING TO YOUR CLAIM.**

Copies of Supporting Documents Attached:      Yes      No

**14. I HEREBY ATTEST THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT I AM COMPETENT TO MAKE THESE STATEMENTS.**

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Date of Complaint

Signature of Complainant

**15. RELEASE OF MEDICAL RECORDS**

I hereby consent to the release to the Maryland Board of Physicians, or its designated investigating body, of medical reports and records related to this occurrence from any hospital, related institution, or physician, including the physician who is the subject of this complaint.

If the Maryland Board of Physicians determines that this complaint is a fee dispute, I consent to sending this complaint to the Consumer Protection Division of the Attorney General's office for mediation.

(Check if Yes)

If block is not checked, this complaint will be dismissed if the Board finds no probable violation of the Maryland Medical Practice Act.

**16. RELEASE OF ADDITIONAL INFORMATION**

I hereby consent to the release of any reports, responses, or any other material that the Maryland Board of Physicians deems necessary from any health care provider who provided treatment to me whether or not this health care provider is mentioned in any part of this complaint.

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Date of Complaint

Signature of Complainant

08/29/13, Revised 10/24/14, 03/20/15, 04/28/16; 7/9/2021