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

1. IDENTIFY THE TYPE OF HEALTHCARE PROVIDER:

_____ Physician
_____ Athletic Trainer
_____ Genetic Counselor
_____ Naturopathic Doctor
_____ Nuclear Medical Technologist
_____ Perfusionist
_____ Physician Assistant
_____ Polysomnographic Technologist
_____ Pychiatrist Assistant
_____ Radiation Therapist
_____ Radiographer
_____ Radiologist Assistant
_____ Respiratory Care Practitioner

2. IDENTIFY THE HEALTHCARE PROVIDER:

Full Name: _____
(Please Print)

Office Address: _____
(Street)

_____
(City) (State) (Zip Code)

Office Telephone: _____-_____-_____

3. PATIENT'S 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 healthcare provider. 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 HEALTHCARE PROVIDER?**

_____

_____

_____

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

_____

_____

_____

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 HEALTHCARE PROVIDER IN YOUR DESCRIPTION.**

The Maryland Board of Physicians (the Board) will contact you for clarification or additional information, if needed. Please concisely describe your primary concern about the healthcare provider listed on your complaint form. If you need more space, attach a separate typed, signed, and dated document.

11. IF THE DIAGNOSIS AND TREATMENT THAT WAS RENDERED, WHICH IS THE SUBJECT OF THIS COMPLAINT, WAS PAID BY A THIRD-PARTY INSURER, IDENTIFY THE INSURER AND PATIENT'S INSURANCE IDENTIFICATION NUMBER.

Insurance Identification Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

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

_____

_____

_____

_____

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.

_____

Date of Complaint Signature of Complainant

15. RELEASE - I hereby consent to:

- Releasing to the Board, or its designated investigating body, medical reports and records related to this occurrence from any hospital, related institution, or healthcare provider, including the healthcare provider who is the subject of this complaint.

- Releasing any reports, responses, or other material that the Board deems necessary from any healthcare provider who provided treatment to me, whether or not this healthcare provider is mentioned in any part of this complaint.

- Sending this complaint to the Consumer Protection Division of the Attorney General's office for mediation if the Board determines that this complaint is a fee dispute.

Date of Complaint Signature of Complainant

Please complete this form and return it by mail, email, or fax to:

Maryland Board of Physicians
INTAKE UNIT
4201 Patterson Avenue
Baltimore, MD 21215
Email: mdh.mbp_intake@maryland.gov
Fax: 410-358-2252

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

The Maryland Board of Physicians (the Board) 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, audiotape.) If you need such accommodation, please notify the Board's 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 Board's compliance with the ADA, please contact Ms. Anderson.

08/29/13, Revised 10/24/14, 03/20/15, 04/28/16; 7/9/2021; 9/15/2023; 3/5/2024