NEW YORK STATE DEPARTMENT OF HEALTH Office of Professional Medical Conduct

**Complaint Form** 

Please print and complete all sections of this form and mail to: Office of Professional Medical Conduct Central Intake Unit 433 River St., Suite 1000, Troy, NY, 12180-2299 (This form must be mailed and include an original signature)

All reports of misconduct are kept confidential and are protected from disclosure according to New York State Public Health Law, Sections 230(10)(a)(v) and 230(11)(a). Any person who reports or provides information to the Board for Professional Medical Conduct in good faith, and without malice, shall not be subject to an action for civil damages or other relief as the result of making the report according to Section 230(11)(b).

| S  | SEE ATTACHED INSTRUCTIONS BEFORE CON   | APLETING    |             |
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| INFORMATION ABOUT YOU                            | ()   |             |             |
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| Address  | - Community  |             |             |
| (No. and Street)                                 | (City)   | (State)     | (Zíp Code)  |
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| (PLEA  | SE PROVIDE A NUMBER WHERE YOU CAN  | BE REACHED) |             |
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| PHYSICIAN OR PHYSICIAN ASSISTANT                 |  |             |             |
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| Name(Last)                                       |  | (First)     | (MI)        |
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| Telephone ()                                     | E  | _           |             |
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| ESCRIBE YOUR COMPLAINT AS COMPLETELY AS YOU CAN. | . PLEASE SIGN AND DATE THE FORM.   |             |             |
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| atient's Name(Last)                              |  | (First)     | (MI)        |
| ate of Birth Day                                 |  |             |             |
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| /here did this happen?                           |  |             |             |
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| ave you filed a complaint with anyone else?      | Yes No   |             |             |
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| yes, with whom?                                  | A SEASON OF  | CHIP SEP    | CO-302-00-1 |
| OH-3867 (07/11) Page 1 of 2                      | A J. MIKES A COMMUNICATION OF THE PARTY OF T |             |             |

NEW YORK STATE DEPARTMENT OF HEALTH

| Office of Professional Medical Conduct |   | Complaint Form |                          |
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|  | {Last Name }                            | (First Name)   | (MI)                     |
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