Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 West Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

COMPLAINT FORM

Please Note: All complaints must be submitted in writing. Complaints cannot be accepted by phone.

The Arizona Board of Osteopathic Examiners in Medicine and Surgery has the statutory authority to regulate osteopathic physicians (D.O.) under Chapter 17 of Arizona Revised Statutes (A.R.S.). The Board's jurisdiction and authority are limited to violations of A.R.S. §32-1800 et seq.

If filling out by hand, please print in blue or black ink:

Your Name:	Your Daytime Phone including Area Code:
Your Mailing Address, including City, State and Zip:	Your Email Address:
Patient's Name:	Patient's Date of Birth:
Your relationship to patient:	Date(s) of Incident(s):

This complaint is being filed against:

Name of Doctor:
Doctor's Practice Name and Address/City/State:

1. Describe in detail what the doctor did (or did not do) that causes you to make this complaint. Use as many pages or additional sheets of paper as you need to describe what happened (who, what, when, where). If you have supporting documents, such as letter, billing statements, photographs, etc. attach COPIES of them to this complaint. You do not need to send medical records; the Board will obtain those from the doctor. **Please note that a copy of your complaint will be provided to the physician to obtain a response to the allegation(s).**

2. Please be advised, the Board's complaint files and records are confidential investigative materials, and by law, availability is restricted pursuant to Arizona Revised Statutes (A.R.S.) §32-1855.03(d).

3. If the complainant is the patient, the patient may be entitled to reimbursement of fees paid to the licensee if the Board concludes that the licensee has engaged in unprofessional conduct that warrants disciplinary action. Please indicate whether the complainant/patient seeks reimbursement of fees paid to the licensee and how much the patient is seeking (A.R.S. § 32-3225).

   Does the patient seek reimbursement of fees paid to the licensee? Yes _____ No ____ . If yes, how much in fees is sought? $__________________.
   (please attach any documentary evidence of the amount of fees paid to the Licensee by the patient or on behalf of the patient.)

Nature of Complaint (Please check all that apply)

- ☐ Substance Abuse
- ☐ Failure to Release Records
- ☐ Insurance Fraud
- ☐ Advertising Issue
- ☐ Misdiagnosis of A Condition
- ☐ Patient Abandonment
- ☐ Incorrect Billing
- ☐ Breach of Confidentiality
- ☐ Inappropriate Physical Contact with a Patient
- ☐ Unnecessary Treatment
- ☐ Record Keeping Issues
- ☐ Issue other than listed: ____________________________

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Signature____ Date Signed _______________

PLEASE EMAIL, FAX or MAIL USING THE CONTACT INFO IN LETTERHEAD