NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE COMPLAINT FORM

Complainant Information:

First Name | Middle Name | Last Name

Street Address | City, State, Zip Code

Home Phone | Cell Phone | Date of Birth

Email Address | Relationship to Patient

Patient Information (if different from above):

First Name | Middle Name | Last Name

Street Address | City, State, Zip Code

Home Phone | Cell Phone | Date of Birth

Email Address

Complaint Against:

☐ Doctor of Osteopathic Medicine ☐ Physician Assistant ☐ Anesthesiologist Assistant

Licensee First Name | Licensee Last Name

Street Address | City, State, Zip Code

License Number (if known) | Office Phone | Email Address (if known)

Completed Form may be returned to:
Nevada State Board of Osteopathic Medicine 2275 Corporate Circle, Suite 210, Henderson, NV 89074
(fax)702-732-2079
Email: osteo@bom.nv.gov

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Please describe your complaint in detail below (use additional paper if necessary):

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Specific Information about your Complaint:

What are the dates the provider in question cared for you/patient? _____

Witnesses Involved: _____

Treatment Received At (please include address if different than listed above)

☐ **Physician's Office:**

☐ **Hospital:**

☐ **Other:**

The information given above and attached is true and accurate to the best of my knowledge. I realize the serious nature of filing such a complaint and recognize that the board may not be able to take action without any cooperation in providing additional information if requested.

_____ _____

Signature of Complainant Date

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