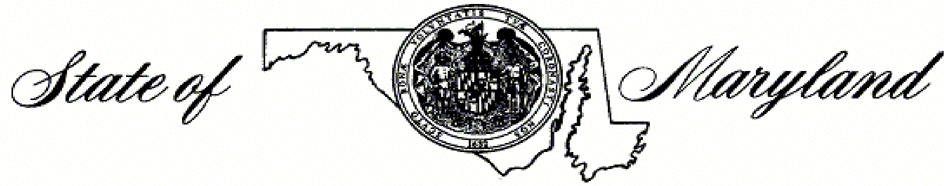

STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

4201 Patterson Ave • Baltimore, MD 21215-2299 • Phone: 410-764-4785 • Fax: 410-358-3083
Toll Free 866-253-8461

COMPLAINT FORM

IDENTITY OF PODIATRIST

Full Name: ____

Office Address: ____

____

Office Telephone: (   ) ____

PATIENT NAME

Full Name: ____

Home Address: ____

____

Home Telephone: (   )____

Other Phone: (   )____

Date of Birth: ____________________

IDENTITY OF COMPLAINANT

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

Full Name: ____

Home Address: ____

____

Home Telephone: (   ) ____

Office Telephone: (   ) ____

Other Phone: (   )____

RELATIONSHIP OF COMPLAINANT TO PATIENT

________ Same ________Spouse ________Relative ________No relation

---

When was the patient treated: ________________________

When did the patient first see the podiatrist: ________________________

For what condition was the patient being treated for by the podiatrist: _____________________

____

PLEASE DESCRIBE WITH AS MUCH DETAIL AS POSSIBLE, THE EXACT NATURE OF YOUR COMPLAINT(S) AGAINST THIS PODIATRIST. INCLUDE IN YOUR DESCRIPTION THE DATE(S) OF THE OCCURRENCE(S).

Use as many additional sheets as necessary. Number each additional sheet and sign each one at the bottom.

HAVE YOU MADE THIS COMPLAINT TO ANY OTHER PERSON OR ORGANIZATION?
YES☐ NO ☐

IF SO, TO WHOM? ____

STATE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE KNOWLEDGE OF YOUR COMPLAINT, INCLUDING OTHER PODIATRISTS.

____

____

____

____

DO YOU HAVE ANY REPORTS OR OTHER WRITTEN COMMUNICATIONS DIRECTED TO YOU WITH RESPECT TO THE MATTERS COMPLAINED OF? YES☐ NO ☐
(*If so, please attach copies of any reports, bills, invoices, or documents supporting your claim)*

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

Insurance Identification Number:____

Insurance Company Name: ____

Insurance Company Address: ____

I HEREBY CONSENT TO THE RELEASE TO THE BOARD OF PODIATRIC MEDICAL EXAMINERS, OR ITS DESIGNATED INVESTIGATING BODY, OF MEDICAL REPORTS AND RECORDS RELATING TO THIS OCCURRENCE FROM ANY HOSPITAL, RELATED INSTITUTION OR HEALTH PROFESSIONAL, INCLUDING THE PODIATRIST WHO IS THE SUBJECT OF THIS COMPLAINT. FURTHERMORE, I CONSENT TO THE RELEASE OF COPIES OF BILLING AND EXPLANATION OF BENEFIT FORMS FROM ANY AND ALL INSURANCE CARRIERS.

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.

If the Board of Podiatric Medical Examiners 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** ________ Check, if **NO** _________

________________________ ____

Date of Complaint **Signature of Complainant**