## VERMONT DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE 108 Cherry Street, PO Box 70 Burlington, VT 05402-0070 (802) 657-4220

## **COMPLAINT FORM**

## **Please Print**

Your information: Last name	First Name
Street address	
City, State, Zip code	
Business/Daytime phone	
Email	
This is a complaint against a:  Physician (MD)  Physician Assistant (PA)  Podiatrist (DPM)	
Full name of Physician, Physician Assistant, or Podia	trist:
Name of health care facility (if known)	
Address	
City, State, Zip code	
Business phone of Physician, Physician Assistant, or	Podiatrist
NATURE OF COMPLAINT: Please describe, in detail, professional. Use the space on the reverse side and	, , , , , ,

Continue your compl	aint here		
Please attach copies pharmacy, or insurar	•	vill help us review you	ır complaint, such as medical,
patient's legally auth	orized representative must	sign the release form	omplaint. The patient or the (attached). We will send you a lease of Medical Records and
Authorization form to formal disciplinary ac	·	e subject of this comp al, the name and othe	plaint. If this investigation results in or information about the person
 Your Signature		 	y's Date
Mail this form to:	VERMONT DEPARTMEN BOARD OF MEDICAL PRA 108 Cherry Street, PO Bo	ACTICE	

**Burlington, VT 05402-0070**