VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
280 State Drive
Waterbury, VT 05671-8320
(802) 657-4220

COMPLAINT FORM

Please Print

Your information:
Last name_____ First Name_____

Street address_____

City, State, Zip code_____

Business/Daytime phone_____ Cell/Home phone_____

Email_____

This is a complaint against a:
Physician (MD) ☐
Physician Assistant (PA) ☐
Podiatrist (DPM) ☐

Full name of Physician, Physician Assistant, or Podiatrist:

_____

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, the nature of your complaint against this professional. Use the space on the reverse side and additional sheets, if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please turn over and complete other side

Continue your complaint here:

Please attach copies of any materials you think will help us review your complaint, such as medical, pharmacy, or insurance records.

We need to be able to review the medical records that relate to this complaint. The patient or the patient's legally authorized representative must sign the release form (attached). We will send you a confirmation letter when we receive your signed Authorization for Release of Medical Records and Complaint Form.

We will likely be sending a copy of your Complaint Form, the information attached to it, and the Authorization form to the professional who is the subject of this complaint. If this investigation results in formal disciplinary action against the professional, the name and other information about the person filing the complaint may become public. Please call us if you have any questions or concerns.

_____ _____

Your Signature Today's Date

Mail this form to: **VERMONT DEPARTMENT OF HEALTH**
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