Print Form

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510-7238
Physical Address: 1105 Terminal Way, Ste. 301, Reno, NV 89502-2144
Phone: In Reno/Sparks/Carson City: (775) 688-2559
(If calling from any other area of Nevada, call the Board's in-state, toll-free number: 888-890-8210)
Fax: (775) 688-2553

COMPLAINT

Please use this form to provide your complaint information and summary. Be as concise as possible. Make copies of any documents you have which support your allegation(s) and attach them to your completed Complaint form. Please mail your completed Complaint form and attachments to the above address, or fax to the above number.

Your Name: _____ Gender (circle): M / F

Phone Number(s) (home/work/cell): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____ Gender (circle): M / F

Patient Date of Birth: _____ Patient Social Security Number: _____

Physician(s), Physician Assistant(s), Practitioner(s) of Respiratory Care, Perfusionists named in complaint:

1) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

2) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

3) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Date(s) of Occurrence: _____

Treatment Received At (please check the following that apply, and include name and address):

☐ Physician's Office: _____

☐ Hospital: _____

☐ Other: _____

Did you obtain a second opinion from another physician? ☐ Yes ☐ No

If "Yes": Name of Physician: _____

Physician Address: _____

Diagnosis: _____

IMPORTANT! *PLEASE SIGN AND DATE*

Signature: _____ Date: _____

COMPLAINT SUMMARY