DEPARTMENT OF HEALTH
MARYLAND BOARD OF PODIATRIC MEDICAL EXAMINERS
4201 PATTERSON AVE. BALTIMORE, MD 21215
Phone (410)764-4785 FAX (410)358-3083 TDD FOR DISABLED MD Relay Service 1-800-735-2258

COMPLAINT FORM

Please complete this form and return to:

Maryland Board of Podiatry
4201 Patterson Avenue, Room 310
Baltimore, MD 21215

If you have any questions, please call 410-764-4785.

1. IDENTIFY THE HEALTH PROVIDER:

Full Name: _____
(Please Print)

Office Address: _____
(Street)

_____
(City) (State) (Zip Code)

Office Telephone: _____

PATIENT NAME:

Full Name: _____
(Please Print)

Home Address: _____
(Street)

_____
(City) (State) (Zip code)

Home Telephone: _____

Patient's Date of Birth:_____/_____/_____

Office Telephone: _____

2. IDENTITY OF COMPLAINANT: The Board cannot guarantee anonymity. Information in the complaint may be shared with the practitioner/licensee.

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

Full Name: _____
(Please Print)

Home Address: _____
(Street)

_____
(City) (State) (Zip code)

Home Telephone : _____

Office Telephone: _____

Date patient was treated: _____ / _____ /_____

3. RELATIONSHIP OF COMPLAINANT TO PATIENT:

☐ Patient ☐ Spouse ☐ Relative ☐ No relation

4. WHAT, IF ANY, ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH THE HEALTH PROVIDER?

_____

_____

_____

5. STATE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE KNOWLEDGE OF YOUR COMPLAINT, INCLUDING ANY OTHER HEALTH PROVIDERS.

_____

_____

_____

The Maryland Board of Podiatry supports the Americans with Disabilities Act and will provide this complaint packet in analternative format to facilitate effective communication with sensory impaired individuals. (For example, Braille, large print, audio tape.) If you need such accommodation, please notify the Board at 410-764-4785 or use the Maryland Relay Services TT/Voice number, 1-800-735-2258.

6. NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL AS POSSIBLE, WHAT EVENT OR EVENTS LED TO THE FILING OF THIS COMPLAINT. INCLUDE THE DATES AND REASON FOR SEEING THE HEALTH PROVIDER IN YOUR DESCRIPTION.

8. NATURE OF COMPLAINT, CONTINUED:

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

Insurance Identification Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

10. LIST THE IDENTITY OF ANY PERSONS TO WHOM YOU HAVE MADE A SIMILAR COMPLAINT, INDICATE WHEN THE COMPLAINT WAS MADE.

_____

_____

_____

_____

11. ATTACH COPIES OF ANY REPORTS, BILLS, INVOICES, DOCUMENTS, OR STUDIES SUPPORTING OR RELATING TO YOUR CLAIM.

Copies of Supporting Documents Attached: ☐ Yes ☐ No

12. 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.

_____

Date of Complaint Signature of Complainant

13. RELEASE OF MEDICAL RECORDS

I hereby consent to the release to the Maryland Board of Podiatry, or its designated investigating body, of medical reports and records related to this occurrence from any hospital, related institution, or physician, including the physician who is the subject of this complaint. Furthermore, I consent to the release of copies of billing and Explanation of Benefits forms from any and all insurance carriers.

_____

Date of Complaint Signature of Complainant

14. RELEASE OF ADDITIONAL INFORMATION

I hereby consent to the release of any reports, responses, or any other material that the Maryland Board of Podiatry deems necessary from any health care provider who provided treatment to me whether or not this healthcare provider is mentioned in any part of this complaint.

_____

Date of Complaint Signature of Complainant