Maryland Department of Health

Office of Controlled Substances Administration

1223 West Pratt Street, Baltimore, MD 21223

Phone (410)764-2890

FAX (410)358-1793

TDD FOR DISABLED

MD Relay Service 1-800-735-2258

COMPLAINT FORM

**ALL INFORMATION PROVIDED IN THIS FORM WILL BE REGARDED AS HIGHLY CONFIDENTIAL. YOUR COMPLAINT WILL NOT BE DISCLOSED TO PRACTITIONER OR

ESTABLISHMENT**				
Completed form can be returned by:				
CLICKING THE SUBMIT	BY EMAIL BU	TTON		
OR				
MAIL TO: Office of Controlled Su 1223 West Pratt Street Baltimore, MD 21223	bstances Adm	ninistration		
OR				
FAX: 410-358-1793				
If you have any questions, please call 410)-764-2890 or 410-7	64-2899		
1. IDENTIFY THE TYPE OF O Practitioner O Pharmacy O Hospital O Distributor O Nursing Home		O	Methadone Program Drug Alcohol Program Animal Control Facility	
2. IDENTIFY THE PRACTIT	IONER OR ES	TABLISHMI	ENT	
Full Name:				
	(Please Print)			
Office Address:	(Street)			
	(Oll Cel)			
	(City)	(State)	(Zip Code)	
Office Telephone:				

3. PATIENT NAME

Full Name: (Please Print) Home Address: (Street) (City) (State) (Zip code) Home Telephone: Office Telephone: DATE PATIENT WAS TREATED: RELATIONSHIP OF COMPLAINANT TO PATIENT O Self O Spouse O Relative O No relation	Home Address: (Street) (City) (State) (Zip code) Home Telephone: Patient's Date of Birth: Office Telephone: IDENTITY OF COMPLAINANT (optional) 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: Office Telephone: DATE PATIENT WAS TREATED: RELATIONSHIP OF COMPLAINANT TO PATIENT O Self O Spouse O Relative O No relation WHAT, IF ANY, ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH		Full Name:						
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3.		INT: PLEASE DESCRIBE, WITH AS MUCH DETAIL AS NT OR EVENTS LED TO THE FILING OF THIS COMPLAINT.
) .	I HEREBY ATTEST THA	AT THE FOREGOING INFORMATION IS TRUE TO THE BEST
	OF MY KNOWLEDGE A STATEMENTS.	ND BELIEF, AND THAT I AM COMPETENT TO MAKE THESE
-	Date of Complaint	Signature of Complainant
		Your typed name above constitutes your electronic signature.