

**Nevada State Board of Medical Examiners
Investigations Division
PO Box 7238 Reno, NV 89510
Physical Address: 1105 Terminal Way, #301 Reno, NV 89502**

**Phone: In Reno: (775) 688-2559
Fax: (775) 688-2553
(or if calling from any other area of Nevada,
call the board's in-state toll-free number: (888) 890-8210)**

COMPLAINT FORM

NOTE: Please print out this Complaint Form on your printer. On the printed Complaint Form, please type or neatly print 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.

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 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 mark the following that apply, including 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:** _____

