STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE
7 Eagle Square
Concord NH 03301

CONSUMER COMPLAINT FORM

1-800-780-4757
1-603-271-6930
1-603-271-6702 (FAX)

Please type or print clearly **Please provide all requested information**

NAME OF PHYSICIAN: _____ **Office Phone:** _____
ADDRESS: _____
_____
NAME OF CLINIC OR HOSPITAL (IF APPLICABLE): _____
_____
NAME OF PERSON REGISTERING COMPLAINT: _____
EMAIL ADDRESS OF COMPLAINANT: _____
RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
_____ **HOME PHONE:** _____
PATIENT NAME: _____ **WORK PHONE:** _____
PATIENT DATE OF BIRTH: _____ **SOCIAL SECURITY #** _____
PATIENT E-MAIL ADDRESS: _____
Has the patient consulted any other physician regarding this same complaint?
If so, please give the name and address: _____
_____

DETAILS OF COMPLAINT

TYPE OF ILLNESS/REASON FOR VISIT: _____

DATE OF VISIT(S) OR INCIDENT: _____

WHAT ARE YOUR SPECIFIC CONCERNS?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Attach additional sheets as necessary.

NOTICE: Please provide as much detailed, factual information as possible. The information on this form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to the licensee or to other government agencies which assist in disciplinary investigations including the Attorney General's Office

SIGNATURE: _____ **DATE:** _____