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Print Form

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Division of Drug Control

4201 PATTERSON AVE. BALTIMORE, MD 21215

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 BUTTON

OR

MAIL TO:
Division of Drug Control
4201 Patterson Avenue
Baltimore, MD 21215

OR

FAX:
410-358-1793

If you have any questions, please call 410-764-2890 or 410-764-2899

1. **IDENTIFY THE TYPE OF HEALTH PROVIDER**

- ○ Practitioner
- ○ Pharmacy
- ○ Hospital
- ○ Distributor
- ○ Nursing Home
- ○ Assisted Living Facility
- ○ Methadone Program
- ○ Drug Alcohol Program
- ○ Animal Control Facility
- ○ Other

2. **IDENTIFY THE PRACTITIONER OR ESTABLISHMENT**

Full Name: _____
(Please Print)

Office Address: _____
(Street)

_____ Alabama _____
(City) (State) (Zip Code)

Office Telephone: _____

3. **PATIENT NAME**

Full Name: _____
(Please Print)

Home Address: _____
(Street)

_____ Alabama _____
(City) (State) (Zip code)

Home Telephone: _____

Patient's Date of Birth: _____

Office Telephone: _____

4. **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)

_____ Alabama _____
(City) (State) (Zip code)

Home Telephone: _____

Office Telephone: _____

5. **DATE PATIENT WAS TREATED:** _____

6. **RELATIONSHIP OF COMPLAINANT TO PATIENT**

○ Self ○ Spouse ○ Relative ○ No relation

7. **WHAT, IF ANY, ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH THE PRACTITIONER OR ESTABLISHMENT?**

8. **NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL AS POSSIBLE, WHAT EVENT OR EVENTS LED TO THE FILING OF THIS COMPLAINT.**

9. 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