COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
HEALTH CARE PROFESSIONS LICENSING BOARD

P.O. Box 502078, Bldg. #1242, Pohnpei Court,
Capitol Hill, Saipan, MP 96950
Telephone: (670) 664-4808/4809 - Fax: (670) 664-4814

CONSUMER COMPLAINT FORM

Please print legibly or type

PERSON REGISTERING THE COMPLAINT			
Last Name: (O *Mr.* O *Mrs.* O *Ms.*)	First Name:	Middle Name	
Mailing Address	City	State	Zip Code
Phone No: (Daytime No.)	(Evening No.)	(Cell No.)	(Email Address)
Your Relationship to Patient:		Patient Date of Birth:	
Patient's Name: (O *Mr.* O *Mrs.* O *Ms.)*			

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page.

- ☐ **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)
- ☐ **Prescribing Issues** (e.g., excessive/under prescibing, Internet)
- ☐ **Unlicensed Provider or Aiding/Abetting unlicensed practice**
- ☐ **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)
- ☐ **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)
- ☐ **Office Practice** (e.g., Failure to provide Medical Records to Patient, Failure to Sign Death Certificate, Patient abandonment)
- ☐ **Sexual Misconduct**
- ☐ **Other:** ____________________

NOTICE: Except for the name of the physician or other healthcare provider, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings to determine whether a violation of the Commonwealth Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Office of the Attorney General.

COMPLAINT REGISTERED AGAINST

I wish to file a complaint against the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

NAME: ____

(Last Name) (First Name) (Middle Name)

Office/Facility Name: ______________________ **License No** (if known)**:** ______________

Address: ____

(Street) (City) (State) (Zip Code)

Phone Number: ____

Has the patient been examined/treated by another physician/provider for this same condition?

☐ **No** ☐ **Yes** **If yes, provide name and address on the "Authorization for Release of Medical Information Form".**

Reason for Treatment: ____

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Date (s) of Treatment: ____

DETAILS OF COMPLAINT

(Attached additional sheets if necessary)

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(Signature) (Date)