IOWA BOARD OF MEDICINE
400 SW EIGHTH STREET
SUITE C
DES MOINES, IOWA 50309
PHONE: 515-281-5171
FAX: 515-281-8641
Web: www.medicalboard.iowa.gov

COMPLAINT FORM

One of the most important ways the Iowa Board of Medicine protects consumers is by investigating their complaints against physicians. This form helps the Board collect basic information to review your complaint. For an explanation of the complaint investigation process, please call the Board's Enforcement Division, 515-281-5847, or visit the Board's website, **www.medicalboard.iowa.gov** Please provide the following information so that the Board can acknowledge receipt of your complaint and contact you should additional information be needed:

NAME: _____
(LAST) *(FIRST)* *(MIDDLE INITIAL)*

ADDRESS: _____

_____

_____

_____

DAYTIME PHONE: _____
(AREA CODE)

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____
(MONTH/DAY/YEAR)

YOUR GENDER:
(CHECK ONE)

☐ **Male**
☐ **Female**

PATIENT INFORMATION

NOTE: If you are not the patient, please provide the following information:

PATIENT'S NAME: _____
(LAST) *(FIRST)* *(MI)*

ADDRESS: _____

_____

_____

_____

DAYTIME PHONE: _____
(*AREA CODE)*

E-MAIL ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____
(MONTH/DAY/YEAR)

PATIENT'S GENDER:
(CHECK ONE)

☐ **Male**
☐ **Female**

RELATIONSHIP OF COMPLAINANT TO PATIENT:
(CHECK ONE)

☐ **Patient**
☐ **Spouse**
☐ **Relative** *(SPECIFY:_____)*
☐ **No Relation**

LOCATION WHERE CARE OCCURRED:_____

PHYSICIAN INFORMATION

Please provide the following information about the physician(s) who is the subject of your complaint:

PHYSICIAN'S NAME: _____
(LAST) *(FIRST)*

OFFICE ADDRESS: _____

_____

_____

OFFICE PHONE: _____
(*AREA CODE)*

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PHYSICIAN'S NAME: _____
(LAST) *(FIRST)*

OFFICE ADDRESS: _____

_____

_____

OFFICE PHONE: _____
(*AREA CODE)*

++

PHYSICIAN'S NAME: _____
(LAST) *(FIRST)*

OFFICE ADDRESS: _____

_____

_____

OFFICE PHONE: _____
(*AREA CODE)*

COMPLAINT INFORMATION

Please describe complaint, including dates and issues. (Use additional pages if necessary and add copies of records if available.)

Today's Date:_____

QUESTIONS ABOUT COMPLAINT

1. **Did you discuss the complaint with the physician? ☐Yes ☐No**

Explain:

2. **Did you obtain an opinion from another physician about your complaint? ☐Yes ☐No**

Explain:

3. **Have you contacted another regulatory agency or an attorney about your complaint? ☐Yes ☐No**

Explain:

4. **Do you have/did you have a professional relationship (business, employment, etc.) with the physician? ☐Yes ☐No**

Explain:

5. **Do you have/did you have a personal relationship with the physician? ☐Yes ☐No**

Explain:

YOUR EXPECTATIONS

What would you like the Iowa Board of Medicine to do about your complaint?

MAIL OR FAX FORM

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