North Dakota State Board of Occupational Therapy Practice
PO Box 4005 ▪ Bismarck, ND 58502 ▪ Phone 701-250-0847 ▪ Fax 701-224-9824
Web www.ndotboard.com ▪ Email ndotboard@aptnd.com

COMPLAINT FORM

OFFICE USE ONLY: Date received_____ Complaint number: _____ Reviewed _____

Please ***type*** or ***print legibly*** and return to the above address. Please include all relevant documentation.

PERSON REGISTERING COMPLAINT	
NAME	PHONE NUMBERS
ADDRESS	HOME ( )
CITY STATE ZIP	BUSINESS ( ) CELL ( )

HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD? YES NO

COMPLAINT REGISTERED AGAINST:
NAME _____ **(Please use the full name of the PERSON against whom you are filing the complaint. PLEASE DO NOT USE the name of the facility or company.)**
ADDRESS
CITY STATE ZIP
DAYTIME PHONE

DETAILS OF COMPLAINT

1. DATE OF INCIDENT _____

2. NATURE OF YOUR COMPLAINT. (Check all that apply.)

____ Quality of care, competency
____ Violation of the Board's Law and Rules
____ Conviction having a direct bearing on license or practice
____ Inappropriate contact or conduct with a patient
____ Practicing under a false name
____ Gross negligence in practice
____ Physical or mental disability affecting ability or competency to practice
____ Other - Please describe below

____ Suspect insurance fraud
____ Substance abuse
____ Unethical or unprofessional conduct
____ Allowing an unlicensed, incompetent, or impaired individual to practice
____ Breach of confidentiality
____ False, fraudulent, or deceptive statement on any document in practice

_____

_____

2. Have you communicated your concern to the practitioner or company? Yes No

If yes, on what date and by what means: _____

3. Did the practitioner or the company respond? Yes No

If yes, what was said or done?

_____

_____

4. **STATE YOUR COMPLAINT:** (Please provide a clear and concise description of the nature of your complaint, including dates of occurrence, the names and telephone numbers of witnesses and copies of documents pertinent to your complaint including contracts, photographs, x-rays, and patient records, insurance records, etc.)

(IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEETS OF PAPER)

AFFIDAVIT: I AFFIRM THE PRECEDING AND IT IS TRUE TO THE BEST OF MY INFORMATION AND BELIEF**. I am filing this complaint to notify the Board of the activities of this practitioner so that it may be determined if discipline is warranted. I understand that a copy of this complaint may be provided to the licensee.**

_____ _____

SIGNATURE OF COMPLAINANT DATE

RELEASE OF MEDICAL RECORDS

(*Failure to sign the release may result in a delay of the investigation of your complaint*.)

I hereby authorize and direct you to release to the NDBOTP or its agents all records and information, including x-rays, of any treatment and/or consultation of NAME OF PATIENT _____ as may be requested by the Board or its agent. A copy of my signature on this release shall be authorization and direction to release such records and information as is appropriate to the investigation of the complaint. Only individuals directly involved in the complaint process will have access to these records. Copies of this authority may be utilized with the same effectiveness as an original. **If this complaint involves a minor, this release must be signed by the minor's parent or legal guardian, and authorizes the release of the minor's medical records to the North Dakota State Board of Occupational Therapy Practice and its agents for investigative purposes.**

I also hereby consent to the release of my identity and/or records to other state licensing boards and/or law enforcement agencies.

Date: _____ Signature: _____