

COMPLAINT FORM

PLEASE NOTE: THIS IS **NOT** AN APPLICATION FOR
MEDICAL MALPRACTICE PRELITIGATION SCREENING.
Do not use this form if you wish prelitigation consideration of a personal
injury claim for money damages. Applications for Prelitigation Screenings are
available at www.bom@state.id.state.us under the Prelitigation option.

Please mail your printed or typed complaint to:
Idaho State Board of Medicine, PO Box 83720, Boise, Idaho, 83720-0058.
EXPRESS MAIL: 1755 Westgate Dr., Suite 140, Boise, Idaho, 83704.

I. Name of Complainant: _____

Address: _____

City/State/Zip: _____

Home Telephone: (____) _____ Business Telephone: (____) _____

Cell: (____) _____ FAX: (____) _____

II. Identifying information about Health Care Provider whom the complaint is being made: (Please check appropriate box.)

- MD/DO
- PHYSICIAN ASSISTANT
- Other (SPECIFY) _____

Name of Health Care Provider: _____

Business Address: _____

City/State/Zip: _____

Business Telephone: (____) _____ Business FAX: (____) _____

Date(s) of Incident or Care _____
(Please provide the approximate date(s) you were provided care and/or the date of the incident.)

III. Nature of Complaint: Please provide a factual account of what occurred or your concerns about the care that was provided. Attach additional sheets as needed.
