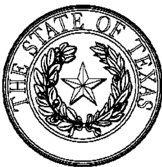


Texas Medical Board

P.O. Box 2018, MC-263, Austin, Texas 78768-2018

Phone: (512) 305-7100 FAX: (512) 305-7007

COMPLAINT FORM

COMPLAINT REGISTERED AGAINST:

Name of Practitioner:

Address:

City, State

Business phone number:

PERSON REGISTERING COMPLAINT:

Name:

Address:

City, State, Zip code

Home Phone:

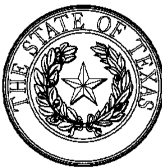
Business Phone:

E-mail:

PATIENT/PERSON HARMED BY THE PRACTITIONER:

Name:

Date of Birth (mm/dd/yyyy):



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DETAILS OF COMPLAINT:

1. Describe your complaint in detail and the events that led to your complaint. Include dates and location of treatment, medications prescribed. You may use additional paper and/or provide other documents to clarify the information given.

2. Have you received a second opinion from another physician? ____yes ____no If yes, please give full name and address.

I have read the preceding, and it is true to the best of my information and belief. If my complaint would be more appropriately addressed by a different agency or society, I authorize TMB to forward my complaint to that agency or society.

____ ____________________
Signature **Date**

To use this version please print, complete and mail to:

Texas Medical Board
Investigations Department, MC-263
P.O. Box 2018
Austin, TX 78768-2018