

STATE MEDICAL BOARD OF OHIO COMPLAINT FORM

Thank you for contacting the State Medical Board of Ohio. Please complete this form and return to:

**Public Inquiries
State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215-6127**

med.ohio.gov

Fax: (614) 728-5946

Your Name _____ Patient's Name _____

Your Address _____

City _____ State _____ Zip _____

Phone Number (____) _____ Work Number (____) _____

The Board is requesting that you provide the patient's date of birth so that the Board may properly identify the patient if a subpoena is sent to the health care provider for copies of the patient's records, as permitted by Section 4731.22(F)(3), ORC.

Date of Birth _____

List the full name, address and phone number of the health care provider(s) you wish to report to the Medical Board:

Provider(s) Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (____) _____

Date of Incident _____

Please describe your concerns regarding your health care provider or staff. You may use additional paper if needed:
