

**INCIDENT REPORT FORM**  
*CONFIDENTIAL*

Date of Report: \_\_\_\_\_

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_  
\_\_\_\_\_

Your Home Phone (\_\_\_\_) \_\_\_\_\_    Work Phone (\_\_\_\_) \_\_\_\_\_    Cell Phone (\_\_\_\_) \_\_\_\_\_

Your Email Address \_\_\_\_\_

**NATURE OF COMPLAINT**

Please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Incompetence      | <input type="checkbox"/> Malpractice                            |
| <input type="checkbox"/> Sexual Misconduct | <input type="checkbox"/> Substance Abuse                        |
| <input type="checkbox"/> Fraud             | <input type="checkbox"/> Failure to transfer or provide records |
| <input type="checkbox"/> Medications       | <input type="checkbox"/> Other: _____                           |

**YOUR COMPLAINT**

**1. Date of Occurrence(s):** \_\_\_\_\_

**2. Name of Doctor you are reporting:** \_\_\_\_\_

Oklahoma License No.: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

**3. Name of Patient (Include age, sex, address and telephone):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

