OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS
4848 N. Lincoln Blvd., Suite 100 Oklahoma City, OK 73105
Telephone: 405/528-8625 Website: www.osboe.ok.gov

REPORT ON PHYSICIAN

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:

- ☐ Incompetence
- ☐ Sexual Misconduct
- ☐ Fraud
- ☐ Medications
- ☐ Malpractice
- ☐ Substance Abuse
- ☐ Failure to transfer or provide records
- ☐ Unprofessional Action by Institution

YOUR COMPLAINT

1. Date of Occurrence(s): _____

2. Name of Doctor you are reporting:_____
Oklahoma License No.: _____

Address: _____

_____

Telephone: (____)_____

3. Full Name of Patient (Include age or date of birth, sex, address and telephone numbers):

_____

_____

_____

4. Narrative Report of what occurred:
(Please provide, in your own words, a detailed statement of your complaint. Be as specific as possible about your concerns. Sign and attach additional pages as necessary. Also, attach copies of any related documents. DO NOT SEND ORIGINALS.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. Witnesses:
(*On a separate sheet of paper, please provide the name, telephone numbers and addresses of all witnesses.)*

6. Do you have a copy of the medical records? □ Yes □ No

***7. If this matter cannot be resolved by this Board, do you wish this Report forwarded to the Osteopathic Association Grievance Bureau? If yes, please initial here _____**

The information included herein is true and correct to the best of my knowledge and belief.

_____ _____
Signature Date

Please mail this form. Do not fax it. Thank you.