



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT REPORT

MISSOURI STATE BOARD OF
 REGISTRATION FOR THE HEALING ARTS

TYPE OR PRINT WITH BLACK INK

Missouri Statutes 575.060 — False Declaration. Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor. Please complete this form and return to: **Missouri Board of Registration for the Healing Arts**, 3605 Missouri Boulevard, Post Office Box 4, Jefferson City, Missouri 65102.

PLEASE NOTE: ALL REQUIRED FIELDS MUST BE FILLED IN OR THIS FORM WILL BE RETURNED TO YOU FOR COMPLETION.

COMPLAINANT INFORMATION

COMPLAINANT NAME (REQUIRED)	TELEPHONE NUMBER (HOME) (REQUIRED)	TELEPHONE NUMBER (WORK)
ADDRESS (STREET, CITY, STATE, ZIP CODE) (REQUIRED)		EMAIL ADDRESS

IF YOU ARE NOT THE PATIENT, WHAT IS YOUR RELATIONSHIP TO THE PATIENT?

- SPOUSE PARENT CHILD OTHER RELATIVE
 FRIEND ATTORNEY OTHER

PATIENT INFORMATION

PATIENT NAME (REQUIRED)	PATIENT DATE OF BIRTH (REQUIRED)	PATIENT SOCIAL SECURITY NO.
PATIENT ADDRESS (IF DIFFERENT THAN ABOVE)	TELEPHONE NUMBER (HOME)	TELEPHONE NUMBER (WORK)

SUBJECT OF COMPLAINT

PROFESSIONAL'S NAME (FULL, FIRST & LAST) (REQUIRED)	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) (REQUIRED)	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, counselor, hospital, clinic, or any other health provider, medical records custodian or any person or corporation (including insurance companies) which have records relating to medical, psychiatric, counseling or evaluation received by me to furnish the Missouri Board of Healing Arts, or its representative, oral or written statements or testimony in any hearing and any and all information with respect to any medical, psychiatric, counseling or evaluation and copies of all hospital, medical, psychiatric, counseling and evaluation records.

A photocopy of this authorization shall be accepted the same as the original in all instances.

PATIENT'S FULL NAME (REQUIRED)	DATE OF BIRTH (REQUIRED)	SOCIAL SECURITY NUMBER (REQUIRED) **USED FOR IDENTIFICATION PURPOSES ONLY
ADDRESS		
TELEPHONE NUMBER		
PATIENT SIGNATURE (OR GUARDIAN/LEGAL REPRESENTATIVE) (REQUIRED)		

DETAILS OF COMPLAINT**NATURE OF COMPLAINT**

Substandard Medical Care	Inappropriate Prescribing
Professional Misconduct	Patient Neglect/Abandonment
Sexual Misconduct	Billing for Services Not Rendered
Rude/Discourteous Behavior	Fraud
Impaired by Alcohol/Drugs	False Advertising
Unsanitary Office Practices	Other
Failed to Provide Medical Records	

Please list all doctor(s) and hospital(s) that patient has been treated by/at regarding the **medical issue being complained about** and the approximate date of treatment. If the doctor or hospital is out of the state of Missouri, please indicate such. **(required)**

DOCTOR/HOSPITAL NAME	DATES TREATED	DOCTOR/HOSPITAL NAME	DATES TREATED

Describe your complaint here. **If you need more space, please continue on another sheet of paper.**

ATTACH COPIES OF ANY AND ALL RELATED DOCUMENTS TO THIS FORM

COMPLAINANT'S SIGNATURE (REQUIRED)



DATE