

# Alabama State Board of Prosthetists and Orthotists

## Complaint Form

*Please type or print clearly.*

**Please note** that all of the information supplied on this form may be subject to public disclosure.

### **Complainant Information**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME TELEPHONE NUMBER: \_\_\_\_\_  
(include area code)  
WORK TELEPHONE NUMBER: \_\_\_\_\_  
(include area code)  
FAX NUMBER: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_  
DATE: \_\_\_\_\_

### **Complaint Reported Against**

NAME: \_\_\_\_\_  
BUSINESS NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
(include area code)  
TITLE: \_\_\_\_\_  
LICENSE NUMBER (IF KNOWN): \_\_\_\_\_  
DATES OF TREATMENT/SERVICE:  
FROM: \_\_\_\_\_ To: \_\_\_\_\_

1. What is the relationship between the complainant and the consumer or patient?

- |   |   |
|---|---|
| <input type="checkbox"/> Self           | <input type="checkbox"/> Spouse                       |
| <input type="checkbox"/> Parent         | <input type="checkbox"/> Son/Daughter                 |
| <input type="checkbox"/> Friend         | <input type="checkbox"/> Brother/Sister               |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Other (please specify) _____ |

2. Please provide the following information about the consumer or patient if he or she is someone other than the complainant

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Month Day Year  
Address: \_\_\_\_\_  
Street address City State ZIP code  
Home telephone number: \_\_\_\_\_ Work telephone number: \_\_\_\_\_  
(include area code) (include area code)

3. Please provide the following information about any other practitioner or licensee involved in the matter about which you are filing a complaint.

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ License number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street address City State ZIP code  
Telephone number: \_\_\_\_\_  
(include area code)

Name: \_\_\_\_\_  
Title: \_\_\_\_\_ License number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street address City State ZIP code  
Telephone number: \_\_\_\_\_  
(Include area code)

4. Please provide the following about anyone who was a witness to the matter about which you are filing a complaint.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street address City State ZIP code  
Daytime telephone number: \_\_\_\_\_ Evening telephone number: \_\_\_\_\_  
(include area code) (include area code)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street address City State ZIP code  
Daytime telephone number: \_\_\_\_\_ Evening telephone number: \_\_\_\_\_  
(include area code) (include area code)

5. What is the nature of the complaint? *(Please check all that apply and provide any additional comments on a separate sheet of paper)*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Administrative/Record keeping        | <input type="checkbox"/> Advertising   | <input type="checkbox"/> Fees/Billing Practices     |
| <input type="checkbox"/> Fraud                                | <input type="checkbox"/> Incompetence  | <input type="checkbox"/> Insurance Fraud            |
| <input type="checkbox"/> Professional/Occupational Misconduct | <input type="checkbox"/> Sexual Misconduct   | <input type="checkbox"/> Substance Abuse/Impairment |
| <input type="checkbox"/> Unlicensed Practice                  | <input type="checkbox"/> Briefly explain the problem if it is not listed above:<br>_____ |   |

6. Please describe the facts of your complaint in the order in which they happened. Type or print clearly. You may use additional sheets of paper if they are needed.

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7. Please describe any action taken to resolve this matter prior to contacting the Board. Remember to type your response or print clearly. You may use additional sheets of paper if they are needed.

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All complaints must be accompanied by **readable copies** (No Originals) of any complaint-related contracts, bills, receipts, canceled checks, correspondence or any other documents you feel are relevant to your complaint.

8. I certify that the statements made by me in this complaint are true and any documents attached are true copies. I am aware that if any statements made by me are willfully false, I am subject to penalties by the Board.

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Signature\*

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Date

Return To:

Alabama State Board of Prosthetists and Orthotists

P. O. Box 1052

Montgomery AL 36101

\* This certification must be signed by the person who has completed the form.