



**DIVISION OF MEDICAL QUALITY ASSURANCE  
Consumer and Investigative Services**

Health care practitioners are regulated by the Department of Health and the action which may be taken is administrative in nature, e.g., reprimand, fine, restriction of practice, remedial education, administrative cost, probation, license suspension or license revocation. The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

**COMPLAINT FORM INSTRUCTIONS**

The Department of Health investigates complaints and reports involving health care practitioners and enforces appropriate Florida Statutes.

**ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT INCLUDE:**

- \* **Fee disputes** (i.e. broken or missed appointments)
- \* **Billing disputes** (i.e., the amount a physician charges for services).
- \* **Personality conflicts**
- \* **Bedside manner or rudeness of practitioners** (such as the physician or his/her office staff's attitude or professionalism)

**HOW TO FILE A COMPLAINT/REPORT AGAINST A HEALTH CARE PRACTITIONER:**

- To file a complaint/report, you must do so in a signed, written report. For your convenience you may use this form providing dates and details about your complaint.
- Use a separate complaint form for each practitioner you wish to file a complaint against.
- Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint.
- Medical records are needed to process your complaint. Since a health care practitioner cannot disclose his or her patient names or records with authorization, the Authorization for Release of Patient Information form included on page 3 must be completed and signed. **Signatures must be witnessed or notarized.**
- The Department will acknowledge receipt of your complaint or report by letter.
- If the allegations contained in your complaint/report are determined to be possible violations of applicable laws and rules, your complaint will be opened for investigation.
- Please note that if your complaint is assigned for investigation, a copy of the complaint form will be provided to the health care practitioner pursuant to Florida law.
- The Department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.

If you have questions about the complaint process, contact the Consumer Services Call Center in Florida toll free at 1 (888) 419-3456, or the Consumer Services Unit at (850) 245-4339.



# HEALTHCARE PRACTITIONER COMPLAINT FORM

## COMPLAINANT/REPORTER

Your Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

## SUBJECT OF COMPLAINT/REPORT

## HEALTHCARE PRACTITIONER INFORMATION

Provider's Name: \_\_\_\_\_  
*Last First M.I.*

Practice Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

Profession: \_\_\_\_\_ (i.e. doctor, dentist, nurse, etc.)

License Number: \_\_\_\_\_ (if known)

## PATIENT INFORMATION

(Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

## YOUR RELATIONSHIP TO PATIENT

- Self  Parent  Son/Daughter  Spouse  Brother/Sister  Friend  Other Practitioner

\*\*\* Legal Guardian/provide court documents  Other \_\_\_\_\_

## NATURE OF COMPLAINT/REPORT

(Please check all that apply.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Quality of care           | <input type="checkbox"/> Inappropriate prescribing             | <input type="checkbox"/> Excessive test or treatment        |
| <input type="checkbox"/> Misdiagnosis of condition | <input type="checkbox"/> Sexual contact with patient           | <input type="checkbox"/> Failure to release patient records |
| <input type="checkbox"/> Substance abuse           | <input type="checkbox"/> Insurance fraud                       | <input type="checkbox"/> Impairment/medical condition       |
| <input type="checkbox"/> Advertising violation     | <input type="checkbox"/> Misfilled prescription                | <input type="checkbox"/> Patient abandonment/neglect        |
| <input type="checkbox"/> Unlicensed                | <input type="checkbox"/> Problem other than listed above _____ |   |

Have you attempted to contact the practitioner concerning your complaint?  Yes Date: \_\_\_\_\_  No

Would you be willing to testify if this matter goes to a formal hearing?  Yes  No

If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority?  Yes  No

If yes, state the name of the person or office that you contacted. \_\_\_\_\_ When did you make this contact? \_\_\_\_\_ Please give case number if available. \_\_\_\_\_

\*\*\*NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.

**PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS RELATIVE TO YOUR COMPLAINT.**

Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating

**WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)**

Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	

**Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (attach additional sheets if necessary).**

**I have attached copies of medical records, correspondence, contracts, and any other documents that will help support your complaint.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WHAT WOULD SATISFY YOUR COMPLAINT?**

\_\_\_\_\_

\_\_\_\_\_

**Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required to file complaint)



**Please mail this form to:  
Florida Department of Health  
Consumer Services Unit  
4052 Bald Cypress Way, Bin C-75  
Tallahassee, Florida 32399-3275**





**QUESTIONNAIRE TO ACCOMPANY COMPLAINTS OF UNLICENSED PRACTICE**

If you know the subject of your complaint, what is your relationship to the subject? \_\_\_\_\_

How did you become aware of the alleged unlicensed practice? \_\_\_\_\_

When did you become aware of the alleged unlicensed practice? \_\_\_\_\_

Location of Occurrence of the alleged unlicensed practice: \_\_\_\_\_

Time/Date/Location of Treatment or Incident: \_\_\_\_\_

If payment was made, how was subject paid? \_\_\_\_\_

Does the subject or subject's business accept Medicaid?  Yes  No Medicare?  Yes  No

Physical description of subject:

Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_

Description of Vehicle:

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Tag No: \_\_\_\_\_ Color: \_\_\_\_\_

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Have you notified law enforcement or any other Agency about the offense?  Yes  No

If yes, please provide the case number and name of investigator assigned to your case: \_\_\_\_\_

Name and telephone number of Agency: \_\_\_\_\_  
\_\_\_\_\_

Names and addresses of other individuals aware of your complaint:

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

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

Names of other subjects/licensees at the same location or business: \_\_\_\_\_

**CONFIDENTIAL INFORMANT SECTION:**

**If you wish to remain anonymous you may become a Confidential Informant. Pursuant to Florida Statutes dealing with the investigation of Criminal Activities, the Department may investigate complaints made by a Confidential Informant. You do not have to provide your name. If you prefer to become a Confidential Informant, your identity will only be disclosed by the department under the order of a judge having jurisdictional authority.**

For Official Use Only  
\_\_\_\_\_  
\_\_\_\_\_