

# Professional Discipline Complaint Form

## Instructions for Completing Complaint Form

To complain about service or treatment by a licensed professional, or about illegal practice of a profession by an unlicensed person, complete the COMPLAINT form on page 2. Please note that we do not have authority to investigate fees you believe are too high or to intervene in fee disputes. However, we can investigate complaints involving fraudulent billing.

Type or print clearly in black ink. Describe your complaint as completely as you can. If you do not have a daytime telephone number, it is helpful if you can provide a number where a message can be left for you during the day. If you have any papers that may support your complaint, such as bills or correspondence, please attach copies. Do not send originals. If you have physical evidence, such as incorrectly dispensed medications, it is important for you to retain that evidence in its original condition.

Be sure to sign and date your complaint. Send it to one of the regional Offices of Professional Discipline. When your complaint is received, it will be assigned to an investigator who will contact you in writing or by telephone. You will have an opportunity to explain your complaint in more detail. If we do not have the authority to investigate your complaint we will refer it to the appropriate agency.

Also, complete the **AUTHORIZATION** portion of this form by entering your name and the name of the practitioner and/or hospital in the appropriate spaces. The Authorization directs the professional, hospital, or other facility to release information about your treatment or the services rendered to you. Sign and date the Authorization, and have it signed and dated by a witness. A witness can be any person 18 years or older. The Authorization does not have to be notarized. Please note that if you leave the Authorization blank, it may delay the investigation of your complaint.

**IMPORTANT!** Complaints against physicians (general practitioners, internists, cardiologists, gynecologists, pediatricians, urologists, surgeons, radiologists, oncologists, anesthesiologists, ophthalmologists, orthopedists, and others) should be sent to: New York State Department of Health, Office of Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Albany, NY 12204. **ALL OTHER COMPLAINTS SHOULD BE SENT TO ONE OF THE OFFICES LISTED BELOW. SENDING THE COMPLAINT TO THE WRONG AGENCY WILL DELAY THE INVESTIGATION.**

## Office of Professional Discipline Regional Offices

- Albany**  
80 Wolf Road, Suite 204, Albany, NY 12205, Telephone: 518-485-9350, Fax: 518-485-9361
- Bronx/Queens**  
2400 Hasley Street, Bronx, NY 10461, Telephone: 718-794-2457 or 2458, Fax: 718-794-2480
- Brooklyn, Staten Island**  
9 Bond Street, 4th Floor, Brooklyn, NY 11201, Telephone: 718-722-2587, Fax: 718-722-2840
- Buffalo**  
295 Main Street, Suite 924, Buffalo, NY 14203, Telephone: 716-842-6550, Fax: 716-842-6551
- Central Administration**  
1411 Broadway, 10th Floor, New York, NY 10018, Telephone: 212-951-6400, Fax: 212-951-6420
- Long Island**  
250 Veterans Memorial Highway, Room 3A-15, Hauppauge, New York 11788, Telephone: 631-952-7422, Fax: 631-952-1029
- Manhattan**  
163 West 125th Street, Suite 302, New York, NY 10027, Telephone: 212-961-4369, Fax: 212-961-4361
- Mid-Hudson Region**  
One Gateway Plaza, 55 S Main Street, 3rd floor, Port Chester, NY 10573, Telephone: 914-934-7550, Fax: 914-934-7607
- Rochester**  
85 Allen Street, Suite 120, Rochester, NY 14608, Telephone: 585-241-2810, Fax: 585-241-2816
- Syracuse**  
333 East Washington Street, 2nd Floor, Suite 211, Syracuse, NY 13202, Telephone: 315-428-3286, Fax: 315-428-3287

**Information About You**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Evening Telephone \_\_\_\_\_

Email \_\_\_\_\_

**Information On The Person(s) You Are Complaining About**

Name(s) \_\_\_\_\_

Profession \_\_\_\_\_ Telephone \_\_\_\_\_

Name of Hospital/Business/Store (if applicable) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Describe your complaint here. Be specific. What happened? When? Where? Type or use black ink. Use additional sheets if necessary. Please read the instructions on page 1 carefully before describing your complaint.

To the best of my knowledge, the information in this complaint is true and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Check here if you have included additional sheets or other material.

I, (print your name here) \_\_\_\_\_, request and authorize the above-named licensed professional or practitioner and/or any other licensed professional or practitioner, and the above-named hospital or facility and/or any other hospital or facility, to disclose fully to the New York State Education Department and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional, practitioner, hospital, or facility.

Name of practitioner(s) \_\_\_\_\_

Name of hospital(s) or other facilities \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_