Governor
Douglas A. Ducey

State of Arizona Naturopathic Physicians Medical Board
1740 W Adams Suite 3002 Phoenix, AZ 85007 Phone 602 542-8242 FAX 602-542-3093 wwww.aznd.gov

COMPLAINT FORM

Americans with Disability – Alternative Format of Complaint
Title H of the Americans With Disabilities Act prohibits the Board from discriminating on the basis of disability in its complaint process. An individual with disability who needs this complaint form to be in an alternative format or who requires a reasonable accommodation to use the complaint process may contact the Board ADA coordinator at the above telephone numbers to make their needs known.

Person Filing Complaint:

Last Name____ First Name ____

Email Address____ Phone Number ________________________

Address____ City_____________________________ State_______ Zip_____

Name of Patient: i*f applicable*

Last Name ____ First Name ____

Your relationship to the Patient ______________________________________ Patients number ____________________________

Name of Physician:

Last Name ____ First Name ____

Name of Practice ____

Address ____City__________________________State _________ Zip _____

Practice Phone Number _______________________________________

Describe specifically your complaint against the Naturopathic Medical Doctor. Please provide copies of any documents, billing statements, and/or any other evidence you believe would support your complaint.

When and where did the event(s) occur?

Date________________________ Where ____

What allegations(s) do you have against the doctor?
Below you will type your summary of complaint (use additional sheets if necessary)

I hereby request the State of Arizona Naturopathic Physicians Medical Board investigate my complaint against the above named Doctor. I hereby attest that the information contained in this complaint and any information and documents attached to this complaint are filed in good faith.
I agree to testify under oath to the information given in this complaint, should the Board request me to Yes No
I understand that the Board may obtain my medical records.

Signature ____ Date ___________________________