Complaint Report Form

South Dakota Board of Medical & Osteopathic Examiners
101 N Main Ave Suite 301
Sioux Falls, SD 57104
(605) 367-7781

This form is used to file complaints with the South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) regarding the following medical professionals:

- Physicians (MD/DO)
- Paramedics/Emergency Medical Technicians (EMT)
- Athletic trainers (AT)
- Dietitians/nutritionist (LN)
- Genetic counselors (GC)
- Occupational therapists (OT)
- Occupational therapy assistants (OTA)
- Physician assistants (PA)
- Physical therapists (PT)
- Physical therapist assistants (PTA)
- Respiratory therapist (RCP)

**Before filing a complaint, you can search for the licensee to ensure the person in one of the above Medical professionals and to check for correct spelling of the name.*

Please note: The SDBMOE does not have jurisdiction over complaints against other health disciplines or facilities listed:

- Chiropractors
- Podiatrists
- Optometrists
- Psychologists
- Dentists
- Nurse practitioners/Registered nurses
- Fee disputes
- Hospitals
- Nursing homes,
- Surgical centers
- Clinics
- or other healthcare facilities.

If the SDBMOE receives a complaint regarding a non-jurisdictional medical professional, you will be notified that the SDBMOE has no jurisdiction.

Please complete the following information concerning your complaint. Please attach any photocopies of documents, including medical records if available, that are pertinent to your complaint. **Do not send original documents.** State in detail all facts which you believe justify your complaint. Use additional paper as necessary.

You will receive confirmation of the receipt of your complaint by letter. If necessary, we may contact you for additional information and you will be notified of a final decision. If an investigation is initiated from your complaint, please be aware that the investigation process takes time and your patience is appreciated.

Please mail this form to:

SDBMOE – Complaint Committee
101 N. Main Ave Suite 301
Sioux Falls, SD 57104

You may also email the form to SDBMOE@state.sd.us.

Name of Complainant (first, middle, last):		
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email address:		

Name of Patient (First, Middle, Last): *If not complainant above*		Date of Birth:
Address:		Phone:
City:	State:	Zip Code:

Complaint Against:
☐physician (MD/DO) ☐Paramedic/Emergency Medical Technician (EMT) ☐athletic trainer (AT)
☐dietitian/nutritionist (LN) ☐genetic counselor (GC) ☐occupational therapist (OT)
☐occupational therapy assistant (OTA) ☐physician assistant (PA) ☐physical therapist (PT)
☐physical therapist assistant (PTA) ☐respiratory therapist (RCP).
**If your complaint involves more than one provider, please fill out separate complaint form for each provider.*

Provider Name (First, Middle, Last):		
Address:		
City:	State:	Zip Code:
License Number (if known)	Phone:	

1. What are the dates that the provider in question cared for you/patient?

2. Have you contacted the provider directly about your complaint? Yes ☐ No ☐

(If yes, what action was taken?)

3. Did any other providers treat you/patient after the alleged incident? Yes ☐ No ☐

(If yes, please specify names and address of other providers)

4. Have you/patient been treated at any hospitals or urgent care facilities related to this complaint?
   Yes ☐ No ☐

(If yes, please identify the facility name and address as well as the date of treatment)

5. Have you filed this complaint elsewhere? Yes ☐ No ☐

(If yes, where?)

6. What action was or is being taken?

7. Please describe your complaint in detail (attach extra sheets if necessary)

PLEASE NOTE: We may forward this complaint to the practitioner in question. Your signed complaint may be a matter of public record.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I FURTHER STATE THAT I WILL VOLUNTARILY APPEAR AND TESTIFY TO THE FACTS IN THIS COMPLAINT IF CALLED UPON BY THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS.

SIGNATURE OF COMPLAINANT _____DATE:_____