



Washington State Department of

**Health**

Medical Quality Assurance Commission

Intake Coordinator

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## Complaint Form

Today's Date: \_\_\_\_\_

### 1. Your Information

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-mail: \_\_\_\_\_

### 2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: \_\_\_\_\_

\_\_\_\_\_

Clinic or Facility: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 3. Patient Information

Full name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of incident: \_\_\_\_\_

