WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Washington State Medical Commission Complaint Form

What can the Medical Commission do?

The Medical Commission is responsible for protecting the public by ensuring high standards of professional conduct, professional education, training and competency among physicians and physician assistants.

We review and investigate complaints about individual physicians (MDs) and physician assistants (PAs). Anyone can make a complaint to us, including: members of the public, employers and other health care staff.

What the Medical Commission cannot do?

We cannot:

- Investigate complaints about anyone who is not a licensed physician or physician assistant. For example;
  - Nurses;
  - Pharmacists;
  - Dentists;
  - Opticians;
  - Social workers;
  - Hospitals;
  - Clinics or other healthcare organizations;
  - Facilities;
- Compensate you or help you make a claim for billing and fee disputes.
- Give legal or medical advice.

Instructions for Completing your Health Care Provider Complaint Form

Please complete all sections to the best of your ability. If a particular section does not apply to your situation, simply write "N/A" (not applicable) in the space.

1. The name of the physician or physician assistant is mandatory to process your complaint, all other information requested is voluntary. We may send information to other government agencies to help with their investigations.
2. Provide the full name (please verify spelling) of the physician or physician assistant you wish to file a complaint against. This complaint cannot be processed without their full name. Please reference the Department of Health provider credential search https://go.usa.gov/xNBqs to verify spelling and help you find their license number.
3. Complete and sign the attached **Authorization to Release Your Name / Identity** and submit it with your complaint.

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Disclosure

Please note that your complaint to the Medical Commission and any attachments will become public record, and is subject to the Public Records Act, RCW 42.56. If requested, your complaint form and attachments or any other written additions to your complaint may be given to the person you complained about.

Today's Date: _____

Your Information	
I am:	☐The Patient ☐Filing this report on behalf of the patient ☐A mandatory reporter
What is your relationship to the patient? ☐Self ☐Parent ☐Child ☐Spouse ☐Sibling ☐Patient's Lawyer ☐Employer ☐Employee ☐Friend ☐Colleague ☐Legal Guardian ☐Other	
Full Name	
Street Address	
City	
State	
Zip Code	
Phone: Home	
Phone: Work	
Phone: Mobile	
E-Mail	
Patient Information	
Patient Full Name	
Date of Birth	
Date of Incident	
Location of Incident	
Date(s) of Care	_____ through _____

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Information about the Physician (MD) or Physician Assistant (PA)

I wish to file a complaint against the individual named below. I understand that the Medical Commission does not assist citizens seeking return of their money or other personal remedies. I am submitting this information so that the Medical Commission may determine if disciplinary action against this practitioner's license should be considered.

I understand that not providing the name of the practitioner will delay or prevent the processing and potential investigation of my complaint.

Attest by initialing here: _____

Name of Treating Practitioner (MD or PA)	
License Number (If Known)	
Name of clinic or facility	
Street Address	
City	
State	
Zip Code	
Phone Number	

Incident Report

Check the box that best describes the nature of your complaint.

- ☐Advertising violation
- ☐Charting irregularities
- ☐Criminal Conviction
- ☐Discrimination
- ☐Excessive Treatment or testing
- ☐Failure to supervise staff
- ☐Inappropriate prescribing
- ☐Insurance / billing fraud
- ☐Mental or physical impairment
- ☐Misdiagnosis of condition
- ☐Misfiled/mislabeled prescription
- ☐Patient abandonment/ neglect
- ☐Quality of Care
- ☐Rude or disruptive behavior
- ☐Sexual misconduct
- ☐Substance abuse
- ☐Unlicensed practice
- ☐Other

Please explain the reason for this complaint. Attach additional sheets if necessary.	
Have you addressed your concerns with the MD/PA?	☐ Yes ☐ No
If yes, what was the result?	
What resolution are you seeking from the Medical Commission?	

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Authorization to Release Your Name / Identity

If you are the patient, employee of the institution where the healthcare was provided or a healthcare professional, your identity is confidential pursuant to **RCW 43.70.075,** unless you waive that right. The Medical Commission may not be able to investigate a case without releasing the identity of the patient or the person filing the complaint.

By signing this document, you waive the right to confidentiality and authorize the Medical Commission to:

- Release your identity to the practitioner you filed a complaint against;
- Release your identity to other persons who are reasonably necessary to the investigation;
- Release your identity for use in any related discipline hearing resulting from your complaint.

Your Waiver Authorization

I hereby waive confidentiality and consent to the release of my identity, for the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings.

☐ **Yes** ☐ **No***

Signature: _____ Date: _____

Printed name: _____ (Please include middle initial)

Date of birth: _____

Home Phone: _____ Day Phone: _____

* I understand this denial may impair the Medical Commission's ability to pursue investigation of this matter and any disciplinary actions.

Once you have completed this form, please scan and email it to Medical.complaints@wmc.wa.gov

If you do not have access to email, please mail it to:
WMC Complaint Intake
PO BOX 47866
Olympia, WA 98504

If you choose to attach any additional materials to this complaint form, the submitted materials will not be returned to you. If you require more information about the Medical Commission or how a complaint is processed, please visit our website at wmc.wa.gov