SOUTH DAKOTA BOARD OF PHARMACY

4001 W. Valhalla Boulevard, Suite 106, Sioux Falls, SD 57106

p - 605.362.2737 f – 605.362.2738 www.pharmacy.sd.gov

COMPLAINT FORM

Name of Person Submitting This Complaint _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____ Phone (____) _____

Name of Pharmacy or Pharmacist Involved:

_____

Address of Pharmacy _____

Pharmacy City _____ State _____ Zip _____

Name of Patient Involved _____

Date of Incident _____

STATEMENT OF COMPLAINT

On the back of this page or on a separate sheet type or neatly print your complaint. A second page is also available for you to type in your information. It is important to be as specific as is reasonably possible. Attach additional pages if necessary. Make copies and attach any documents (such as labels or prescription containers) which will support your allegation(s). After completing your statement of complaint, please sign and date the document. *The Board does not have jurisdiction over complaints involving pricing or billing disputes.*

I hereby declare that all of the information I have provided with this form is true and correct.

_____ _____

Signature of Person Submitting This Complaint Today's Date

STATEMENT OF COMPAINT

Name of Person Submitting This Complaint _____

Name of Pharmacy or Pharmacist Involved _____

Name of Patient Involved _____

Date of Incident _____

STATEMENT OF COMPLAINT: Please fill in below