SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS
407 BELMONT AVENUE
YANKTON, SD 57078
605-668-9017 phone/fax
email: sdbce@iw.net

COMPLAINT QUESTIONNAIRE

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. State in detail all facts which you believe justify your complaint. If possible, state whether the information is within your personal knowledge, and if not, the source or sources of the information. *The Board has no jurisdiction over actions concerning fees.* (PLEASE PRINT OR TYPE)

Name of Complainant: ____

Address: ____

____

Phone: ____

Complaint Against: (First and Last name): ______________________________

Address: ____

____

Phone: ____

ADDITIONAL INFORMATION REQUIRED

What is the date(s) that the chiropractor cared for you?______________________

Did any other individual(s) treat you after the alleged incident? ______________________

Is so, please specify name(s) and address(es): ______________________

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Have you contacted the chiropractor about your complaint? ______________________

What action was taken? ____

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Have you filed a complaint elsewhere? ______________________________

If so, please specify: ____

What action was taken or is being taken?____

Please attach any photocopies of documents, including medical records that are pertinent to your complaint. Do not send your original documents.

Please describe your complaint in detail (attach extra sheets if necessary):____________________

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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 CHIROPRACTIC EXAMINERS.

SIGNATURE OF COMPLAINANT:____

DATE:____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any doctor, hospital, employer, or other person to whom a signed or photo-copy of this authorization is delivered, to furnish all information - reports or copies of records, x-rays and reports/findings of any tests - which may be requested by the South Dakota Chiropractic Board of Examiners and/or Ethics & Disciplinary Committee.

Name of Patient ____
(please print)

Date of Birth ____________________

Address ____
Street City State Zip Code

Date ____________________ Signature ______________________________