SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
27705 460th Avenue, Chancellor, SD 57015
Phone: 605-743-4451 Email: cpmsdlicense@gmail.com
Home Page: doh.sd.gov/boards/midwives/

Complaint Form

Please complete the following information and submit copies of pertinent documents, including medical records if available; do not submit your original documents. State in detail all facts you believe justify your complaint. If possible, state whether information is within your personal knowledge, and if not, provide the source(s).

Please send this completed, signed form to the South Dakota Board of Certified Professional Midwives, attention: Complaints. If necessary, we may contact you for additional information, and you will be notified of the final decision. Please be aware that evaluation and investigation of a complaint is a time consuming process.

Name of Complainant: _____

Address: _____

Phone: _____ Email: _____

Individual(s) against whom this complaint is issued: _____

CPM License # if known: _____

Complaint and Additional Information

Were you the individual for whom care was provided? ☐ Yes ☐ No

If not, for whom was care provided (name and relationship to you)?

_____

Have you contacted the CPM about your complaint? ☐ Yes ☐ No

If so, what action, if any, was taken or is being taken?

_____

Please describe in detail event(s) that caused you to file this complaint; include names, dates, locations, and any other information that you believe support the complaint. Attach extra pages if necessary.

_____

_____

_____

I certify that the above information is true and correct to the best of my knowledge.

Signature of Complainant: _____Date: _____