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STATE OF NEVADA
BOARD OF HOMEOPATHIC MEDICAL EXAMINERS
COMPLAINT

PLEASE PRINT OR TYPE

1. **Name of Doctor complaint is against:** _____
Address: _____
Phone: _____
Your name: _____ **Patient Name:** _____
Address: _____
Phone: _____

2. **Nature of complaint: (Please be specific and brief. Provide any documentation which would support your claim. Use additional sheets if necessary.)**
- _____
- _____
- _____
- _____

3. **Did you obtain a second opinion from another doctor?**
Yes _____
No _____
If yes, please provide a copy of second opinion and the name and address of the doctor. _____

4. **How would you like to see this matter resolved?** _____
- _____
- _____
- _____

06/09/11

page 1 of 3

STATE OF _____)

) ss

COUNTY OF _____)

_____, being first duly sworn, upon oath under penalty of perjury deposes and says: That I am the Complainant above named, that I have read the foregoing Complaint and know the contents thereof, that the same is true of my own knowledge except as to those matters therein stated to be upon information and belief, and as to those matters I believe it to be true. I have read and understand the attached Authorization to Release Information.

Dated this _____ day of _____, 200____.

Complainant

SIGNED AND SWORN TO before me
this _____ day of _____, 200 ____,
by _____

NOTARY PUBLIC

