OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT

Professional Discipline Complaint Form

INSTRUCTIONS FOR COMPLETING COMPLAINT FORM

To complain about service or treatment by a licensed professional, or about illegal practice of a profession by an unlicensed person, complete the COMPLAINT form on the other side of this page. Please note that we do not have authority to investigate fees you believe are too high or to intervene in fee disputes. However, we can investigate complaints involving fraudulent billing.

Type or print clearly in black ink. Describe your complaint as completely as you can. If you do not have a daytime telephone number, it is helpful if you can provide a number where a message can be left for you during the day. If you have any papers that may support your complaint, such as bills or correspondence, please attach copies. Do not send originals. If you have physical evidence, such as incorrectly dispensed medications, it is important for you to retain that evidence in its original condition.

Be sure to sign and date your complaint. Send it to one of the regional Offices of Professional Discipline. When your complaint is received, it will be assigned to an investigator who will contact you in writing or by telephone. You will have an opportunity to explain your complaint in more detail. If we do not have the authority to investigate your complaint we will refer it to the appropriate agency.

Also, complete the **AUTHORIZATION** portion of this form by entering your name and the name of the practitioner and/or hospital in the appropriate spaces. The Authorization directs the professional, hospital, or other facility to release information about your treatment or the services rendered to you. Sign and date the Authorization, and have it signed and dated by a witness. A witness can be any person 18 years or older. The Authorization does not have to be notarized. Please note that if you leave the Authorization blank, it may delay the investigation of your complaint.

IMPORTANT! Complaints against physicians (general practitioners, internists, cardiologists, gynecologists, pediatricians, urologists, surgeons, radiologists, oncologists, anesthesiologists, ophthalmologists, orthopedists, and others) should be sent to: New York State Department of Health, Office of Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Albany, NY 12204. ALL OTHER COMPLAINTS SHOULD BE SENT TO ONE OF THE OFFICES LISTED BELOW. SENDING THE COMPLAINT TO THE WRONG AGENCY WILL DELAY THE INVESTIGATION.

Office of Professional Discipline

Regional Offices

Albany
80 Wolf Road, Suite 204
Albany, NY 12205
Tel: 518-485-9350
Fax: 518-485-9361

Bronx/Queens
2400 Halsey Street
Bronx, NY 10461
Tel: 718-794-2457 or 2458
Fax: 718-794-2480

Brooklyn, Staten Island
9 Bond Street, 4th Floor
Brooklyn, NY 11201
Tel: 718-722-2587
Fax: 718-722-2840

Buffalo
295 Main Street, Suite 924
Buffalo, NY 14203
Tel: 716-842-6550
Fax: 716-842-6551

Central Administration
1411 Broadway, 10th Floor
New York, NY 10018
Tel: 212-951-6400
Fax: 212-951-6420

Long Island
250 Veterans Memorial Highway
Room 3A-15
Hauppauge, New York 11788
Tel: 631-952-7422
Fax: 631-952-1029

Manhattan
163 West 125th Street, Room 819,
New York, NY 10027
Tel: 212-961-4369
Fax: 212-961-4361

Mid-Hudson Region
One Gateway Plaza, 3rd floor
Port Chester, NY 10573
Tel: 914-934-7550
Fax: 914-934-7607

Rochester
85 Allen Street, Suite 120
Rochester, NY 14608
Tel: 585-241-2810
Fax: 585-241-2816

Syracuse
333 East Washington Street, 2nd Floor
Suite 211
Syracuse, NY 13202
Tel: 315-428-3286
Fax: 315-428-3287

INFORMATION ABOUT YOU

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone (Day): _____ (Evening): _____

E-mail address: _____

INFORMATION ON THE PERSON(S) YOU ARE COMPLAINING ABOUT

Name(s): _____

Profession: _____ Telephone: _____

Name of Hospital/Business/Store (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Describe your complaint here. Be specific. What happened? When? Where? Use black ink. Use additional sheets if necessary. Please read the instructions on the reverse side carefully before describing your complaint.

_____

_____

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the information in this complaint is true and complete.

_____ _____
Signature Date

☐ Check here if you have included additional sheets or other material.

I, (print your name here) _____, request and authorize the above-named licensed professional or practitioner and/or any other licensed professional or practitioner, and the above-named hospital or facility and/or any other hospital or facility, to disclose fully to the New York State Education Department and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional, practitioner, hospital, or facility.

Name of practitioner(s): _____

Name of hospital(s) or other facilities: _____

_____ _____
Your signature Date

_____ _____
Signature of witness Date