COMPLAINT REGISTRATION

NORTH DAKOTA BOARD OF PHYSICAL THERAPY

SFN 59629 (11-2010)

Notice of Rights

I understand that I am not legally required to complete this form. It is offered so that the North Dakota Board of Physical Therapy (NDBPT) may properly and thoroughly evaluate and investigate this complaint, and if necessary, submit this information on any legal proceeding. If the NDBPT needs to verify, and, if necessary, legally pursue this complaint, I authorize the NDBPT and/or its agents to disclose this information to those to whom they reasonably believe have a need to know. (This form is a public record and will be made available to members of the public upon request.)

Personal Information

Name	Home Telephone Number	Work Telephone Number	
Address	City	State	ZIP Code

Relationship to Health Care Professional

- ☐ Patient/Client
- ☐ Family/Friend
- ☐ Other Health Care Provider
- ☐ Attorney
- ☐ Third-Party Payor
- ☐ Other - Specify:

Health Care Professional Information

Name		Telephone Number	
Address	City	State	ZIP Code

Statement of Complaint (Use additional sheets as necessary)

Subscribed to and sworn before me.

Date
Signature of Notary Public
Commission Expires

Signature of Complainant
Date