Complaint Process

As a unit of the Division of Consumer Affairs, the Board of Pharmacy (Board), takes its responsibility seriously. A copy of the complaint will be forwarded to the licensee with a cover letter from the Board requiring a detailed written response to the allegations in the complaint. Once that response has been received, it will be reviewed and disposition may be recommended. If the Board needs additional information, the licensee may be required to appear to answer questions concerning the matter.

Please be advised that any information you supply on the complaint form may be subject to public disclosure. If an investigation into the matter is conducted, the information is subject to public disclosure only after the completion of the investigation. You are also advised that the completed complaint form is a “government record,” which the Board may be obligated to provide to anyone making a request pursuant to the Open Public Records Act (OPRA).

You are further advised that pursuant to Section 4B of Executive Order No. 26, information concerning any individual’s medical, psychiatric or psychological history, diagnosis, treatment or evaluation is not a government record subject to public access.

The disposition of the matter may take several months. Please understand that the Board can only take formal action if it finds sufficient basis that the licensee violated State laws or regulations. If the Board determines that formal action is required, the matter is referred to the office of the Attorney General. In that case, formal charges may be filed against the licensee and the licensee will be given an opportunity to defend himself or herself. This process can take a considerable period of time.

If the complaint involves a dispute over fees, please be advised that the Board has limited jurisdiction over fees charged by professionals. If the Board determines that there is insufficient basis to pursue disciplinary action, but determines that the matter involves a fee dispute, your complaint may be referred to the Alternative Dispute Resolution (ADR) Unit of the Division of Consumer Affairs. The ADR is a free mediation service that can be helpful in resolving such matters.

Until a final determination has been made, the Board is not permitted to disclose information regarding the matter. You will be notified in writing when a final determination has been made.
Complaint Form

Please be advised that any information you supply on this complaint form may be subject to public disclosure. If an investigation into the matter is conducted, the information is subject to public disclosure only after the completion of the investigation. You are also advised that the completed complaint form is a “government record,” which the Board may be obligated to provide to anyone making a request pursuant to the Open Public Records Act (OPRA).

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<table>
<thead>
<tr>
<th>Consumer Information</th>
<th>Complaint Reported Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: __________________________</td>
<td>NAME: __________________________</td>
</tr>
<tr>
<td>ADDRESS: ___________________________________________</td>
<td>BUSINESS NAME: __________________________</td>
</tr>
<tr>
<td>CITY: __________________________</td>
<td>ADDRESS: ___________________________________________</td>
</tr>
<tr>
<td>STATE: __________________________ ZIP CODE: ___________</td>
<td>CITY: ___________________________________________</td>
</tr>
<tr>
<td>HOME TELEPHONE NUMBER: __________________________ (include area code)</td>
<td>STATE: __________________________ ZIP CODE: ___________</td>
</tr>
<tr>
<td>WORK TELEPHONE NUMBER: __________________________ (include area code)</td>
<td>TELEPHONE NUMBER: __________________________ (include area code)</td>
</tr>
<tr>
<td>FAX NUMBER: __________________________</td>
<td>TITLE: ___________________________________________</td>
</tr>
<tr>
<td>E-MAIL ADDRESS: __________________________</td>
<td>LICENSE NUMBER (IF KNOWN): ___________________________</td>
</tr>
<tr>
<td>DATE: ___________________________________________</td>
<td>DATES OF TREATMENT/SERVICE: ___________________________</td>
</tr>
</tbody>
</table>

1. What is the relationship between the complainant and the consumer or patient?

- [ ] Self
- [ ] Spouse
- [ ] Parent
- [ ] Son/Daughter
- [ ] Friend
- [ ] Brother/Sister
- [ ] Legal Guardian
- [ ] Other (please specify) ___________________________

2. Please provide the following information about the consumer or patient if he or she is someone other than the complainant.

Name: ___________________________________________ Date of birth: ___________________________ Month Day Year

Address: ___________________________________________ Street address City State ZIP code

Home telephone number: __________________________ (include area code) Work telephone number: __________________________ (include area code)
3. Please provide the following information about any other practitioner or licensee involved in the matter about which you are filing a complaint.

Name: ________________________________________________________________________________________

Title: _________________________________________ License number: _________________________________

Address: ______________________________________________________________________________________

Street address
City
State
ZIP code

Telephone number:______________________________

(include area code)

Name: ________________________________________________________________________________________

Title: _________________________________________ License number: _________________________________

Address: ______________________________________________________________________________________

Street address
City
State
ZIP code

Telephone number:______________________________

(include area code)

4. Please provide the following about anyone who was a witness to the matter about which you are filing a complaint.

Name: ________________________________________________________________________________________

Address: ______________________________________________________________________________________

Street address
City
State
ZIP code

Daytime telephone number:_______________________ Evening telephone number:_______________________

(include area code)

Name: ________________________________________________________________________________________

Address: ______________________________________________________________________________________

Street address
City
State
ZIP code

Daytime telephone number:_______________________ Evening telephone number:_______________________

(include area code)

5. What is the nature of the complaint? (Please check all that apply and provide any additional comments on a separate sheet of paper.)

☐ Administrative/Recordkeeping  ☐ Advertising  ☐ Fees/Billing Practices
☐ Fraud  ☐ Incompetence  ☐ Insurance Fraud
☐ Professional/Occupational Misconduct  ☐ Sexual Misconduct  ☐ Substance Abuse/Impairment
☐ Unlicensed Practice  ☐ Briefly explain the problem if it is not listed above: _____________________________

6. Please describe the facts of your complaint in the order in which they happened. Please print clearly. You may use additional sheets of paper if they are needed.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
7. Please describe any action taken to resolve this matter prior to contacting the Board. Please print clearly. You may use additional sheets of paper if they are needed.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

All complaints must be accompanied by readable copies (NO ORIGINALS) of any complaint-related contracts, bills, receipts, canceled checks, correspondence or any other documents you feel are related to your complaint.

8. I certify that the statements made by me in this complaint are true and any documents attached are true copies. I am aware that if any statements made by me are willfully false, I am subject to punishment.

_______________________________________________ ____________________
Signature* Date

Return to:
Divison of Consumer Affairs
Board of Pharmacy
P.O. Box 45013
Newark, NJ 07101

* This certification must be signed by the person who has completed this form.