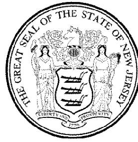



***New Jersey Office of the Attorney General***
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
140 East Front Street, 3rd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100


# Complaint Process

As a unit of the Division of Consumer Affairs, the Physician Advisory Committee (Committee), takes its responsibilities seriously. A copy of the complaint will be forwarded to the licensee with a cover letter from the Committee 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.

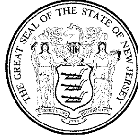
Please be advised that any information you supply on the complaint form may be subject to public disclosure. If an investigation into the matter is conducted, the information is subject to public disclosure only after the completion of the investigation. You are also advised that the completed complaint 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 Committee can only take formal action if it finds sufficient basis that the licensee violated State laws or regulations. If the Committee 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 Committee has limited jurisdiction over fees charged by professionals. If the Committee 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 Committee is not permitted to disclose information regarding the matter. You will be notified in writing when a final determination has been made.

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# Complaint Form

*Please type or print clearly.*

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).

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.

***Consumer Information***

NAME: ______________________________

ADDRESS: ______________________________

CITY: ______________________________

STATE: ______________ ZIP CODE: ____________

HOME TELEPHONE NUMBER: ______________________
(include area code)

WORK TELEPHONE NUMBER: ___ ______________________
(include area code)

FAX NUMBER: ______________________________

E-MAIL ADDRESS: ______________________________

DATE: ______________________________

***Complaint Reported Against***

NAME: ______________________________

BUSINESS NAME: ______________________________

ADDRESS: ______________________________

CITY: ______________________________

STATE: ______________ ZIP CODE: ____________

TELEPHONE NUMBER: ______________________
(include area code)

TITLE: ______________________________

LICENSE NUMBER (IF KNOWN): ______________________

DATES OF TREATMENT/SERVICE:
FROM: ______________ TO: ______________

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

- ☐ Self
- ☐ Parent
- ☐ Friend
- ☐ Legal Guardian
- ☐ Spouse
- ☐ Son/Daughter
- ☐ Brother/Sister
- ☐ 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: ______________________ Work telephone number: ______________________
(include area code) (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) (include area code)

Name: ______________________________

Address: ______________________________
Street address City State ZIP code

Daytime telephone number: ______________ Evening telephone number: ______________
(include area code) (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. Type or 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 Committee. Remember to type your response or 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:

Division of Consumer Affairs
State Board of Medical Examiners
Physician assistant Advisory Committee
P.O. Box 183
Trenton, NJ 08625

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