Health Professions Quality Assurance
PO Box 47865
Olympia, WA 98504-7865
(360) 236-4700 FAX (360) 236-4818
E-Mail hpqa.csc@doh.wa.gov

Health Care Provider Type: _____
(This line must be completed to assure complaint is forwarded to the correct staff. Indicate if the person is a registered nurse, medical doctor, nursing assistant, massage therapist, etc.)

Health Professions Complaint Form

Please keep in mind that the Department cannot help you:

- bring suit against a health care provider for money;
- handle a fee dispute between you and your health care provider;
- discipline health care providers who are not required to be regulated by the Department of Health;
- get money back that you feel is owed to you;
- resolve questions about disability compensation or insurance reimbursement;
- resolve issues involving rudeness by a health care provider or
- resolve issues involving typing errors, miscommunication, or a mistake of facts.

Your Information

(It may be necessary to contact you for additional information.)

Your name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Work ( ) _____ Home ( ) _____

Health Care Provider Information

(Please provide as much information as you can.)

Name of Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Work ( ) _____ Home ( ) _____

Date(s) or time period you received treatment or service: _____

_____

If this report pertains to a Patient, please provide the full name and birth date of the Patient, if known. This information is necessary for the Department to obtain medical records.

Patient's Full Name _____

Patient's Birth Date _____

Please state your complaint in the space provided below. Please be as specific and complete as possible. You may attach additional sheets if necessary. You will receive an acknowledgement letter once your complaint is received. You will be informed of any action taken by this office.

Your Name: _____

Date you submitted this complaint: _____