

Email address:

California State Board of Pharmacy 2720 Gateway Oaks Drive, Suite 100 Sacramento, CA 95833

Phone: (916) 518-3100 Fax: (916) 574-8614

www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency Department of Consumer Affairs Gavin Newsom, Governor



CONSUMER COMPLAINT FORM

NOTICE: The information included on the complaint form is requested per section 129 and section 4008 of the Business and Professions Code. All information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. The information on the complaint form will be used in part to determine whether a violation of state pharmacy law has occurred. If a violation is confirmed, the information may be transmitted to other government agencies, including the Attorney General's Offices.

PLEASE PRINT OR TYPE AND PROVIDE ALL THE REQUESTED INFORMATION.

Name of person register				
Address:				ip Code:
City:	County:	State:	Zi	p Code:
Work phone number:		Home phone nu	ımber:	
Relationship to patient:				
Name of pharmacu				
Name of pharmacy:				
City:	County		tato:	Zip Code:
Name of pharmacist if k	County	s	tate.	zip code
Name of pharmacist if k	n involved:			
Name of any other person	Jii iiivoiveu.			
When did the problem o	ccur?			
Desc	cribe the events in th	ETAILS OF COMPLAINT ne order they happened, extra sheets if necessar		ossible.

Have you discussed this matter with the pharr		☐ Yes				
Name of person contacted:			act:			
How? ☐ By phone ☐ By lett		☐ In person				
Result of contact:						
Further information (complete only if applica	ıble)					
Prescribing doctor name:			Telephone:			
Address:						
Medication prescribed:		,	Prescription number:			
Medication received:						
The Prescription						
\square Was for a new medication \square Was a						
☐ Was a new prescription for a medication th	at had been	taken or used	previously			
	п.	.				
Was there any harm to the patient? ☐ Yes			·			
Brief description:						
Did the pharmacist consult with you regarding	your medic	ation at the ti	me it was dispensed? Yes			
No Was any of the medication take or used?						
Do you still have the medication/receipt?						
Do you still have the container/label/receipt?						
Are you the patient? Yes No If no, what is the patient's name?						
What is your relationship to the patient?						
Are you the legal guardian of the patient?						
IF YOU HAVE THE MEDICATION AND/OR CON	TAINER, PLE	ASE RETAIN TH	HEM UNTIL FURTHER NOTIFIED BY A			
BOARD INSPECTOR.						
IF ADDUCABLE DIFACE ATTACH TO THE FORM	NA CODIEC O		INVOLVED / ana animi an			
IF APPLICABLE, PLEASE ATTACH TO THIS FORI			• • • • • • • • • • • • • • • • • • • •			
bills/invoices received, canceled checks, corre	sponaence,	etc.j. DO NO I	SEND UKIGINALS.			
Signature	Date					

PLEASE COMPLETE THE ATTACHED MEDICAL RELEASE FORM AND RETURN WITH THE CONSUMER COMPLAINT FORM.

INFORMATION COLLECTION, ACCESS AND DISCLOSURE

The information you provide on this complaint form is maintained by the Executive Office of the Board of Pharmacy, 2720 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833. The information is requested pursuant to Business and Professions Code Sections 325 and 326.

Submission of all information requested is voluntary. However, please be aware omission of any information may result in your complaint being rejected as incomplete.

Your completed complaint form becomes the property of the Board and will be used by authorized personnel as appropriate. Information concerning your complaint may be transferred to other governmental or law enforcement agencies.

You have the right to review the records maintained on you by the Board unless the records are exempt by section 1798.40 of the Civil Code. You may gain access to the information by contacting the Board at the above address.

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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY DEPARTMENT OF CONSUMER AFFAIRS GAVIN NEWSOM, GOVERNOR

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I.	, hereby authorize
(Complainant/Patient)	(Date of birth)*
(Person or entity and telephone number from	m which information may be obtained)
course of my treatment to the Board of Pharma	swer any questions pertaining to the diagnosis and acy (Board) and its representatives, including, but on their request. I further agree to allow the Board file an administrative action based upon my
(Person/business being complained about – in	nclude license/registration number if known)
conjunction with any investigation and possible state and/or federal laws and regulations. I fur may release any and all of my records and treat agency which requests, or has been provided vinto other possible violations of state and/or fe shall be valid until completion of an investigat	ntained in confidence and will be used solely in le legal proceeding regarding any violations of orther agree that the Board and its representatives atment information to any other government with, such information as part of an investigation ederal laws and regulations. This authorization tion and prosecution, including any investigation acy that has requested, or been provided with, your
A copy of this authorization shall be as valid a receive a copy of this authorization if requeste	as the original. I understand that I have a right to ed by me.
Complainant/Patient Signature	Date
	OR
Complainant's/Patient's Representative and R	Relationship Date
*Date of birth is needed to positively establish th	ne identity of the patient

(17I-20 Rev. 02/2008)