California State Board of Pharmacy
1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

CONSUMER COMPLAINT FORM

PRINT RESET

***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 — PLEASE PROVIDE ALL THE REQUESTED INFORMATION

E-mail address:			
Name of Person Registering Complaint:		Name of Pharmacy:	
Address:		Address:	
City:	County:	City:	County:
State:	Zip Code:	State:	Zip Code:
Phone No: Wk:( ) Hm ( )		Name of Pharmacist if known:	
Relationship to Patient:		Name of Any Other Person Involved:	
WHEN DID THE PROBLEM OCCUR?			

DETAILS OF COMPLAINT

Describe the events in the order they happened, as simply as possible. (Use extra sheets if necessary.)

_____

_____

_____

HAVE YOU DISCUSSED THIS MATTER WITH THE PHARMACIST? ☐ YES ☐ NO

Name of person contacted_____ Date of contact_____

How? ☐ By phone ☐ By letter ☐ In person

Result of contact_____

_____

FURTHER INFORMATION (complete only if applicable)

Prescribing Doctor: Name_____ Telephone (_____) _____

Address_____City_____St._____ZIP_____

Medication Prescribed_____Prescription Number_____

Medication Received_____

The Prescription

☐ Was for a new medication ☐ Was a refill ☐ Was a new prescription for a medication that had been taken or used previously.

Was there any harm to the patient? ☐ Yes ☐ No Brief Description_____

_____

Did the pharmacist consult with you regarding your medication at the time it was dispensed? ☐ Yes ☐ No

Was any of the medication taken or used? ☐ Yes ☐ No

Do you still have the medication/receipt? ☐ Yes ☐ No Do you still have the container/label/receipt? ☐ Yes ☐ No

IF YOU HAVE THE MEDICATION AND/OR CONTAINER, PLEASE RETAIN THEM UNTIL FURTHER NOTIFIED BY A BOARD INSPECTOR.

IF APPLICABLE, PLEASE ATTACH TO THIS FORM COPIES OF ANY PAPERS INVOLVED (prescription, bills/invoices received, cancelled checks, correspondence, etc.). DO NOT SEND ORIGINALS.

_____ _____

Signature **Date**

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

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ _____, hereby authorize
(Complainant/Patient) *(Date of birth)**

_____

(Person or entity and telephone number from which information may be obtained)

to disclose all records and information and answer any questions pertaining to the diagnosis and course of my treatment to the Board of Pharmacy (Board) and its representatives, including, but not limited to, investigators and legal staff, upon their request. I further agree to allow the Board and its representatives to process and possibly file an administrative action based upon my complaint against:

_____
(Person/business being complained about – include license/registration number if known)

I understand that this information will be maintained in confidence and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of state and/or federal laws and regulations. I further agree that the Board and its representatives may release any and all of my records and treatment information to any other government agency which requests, or has been provided with, such information as part of an investigation into other possible violations of state and/or federal laws and regulations. This authorization shall be valid until completion of an investigation and prosecution, including any investigation and proceeding by another governmental agency that has requested, or been provided with, your records and information.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

_____ _____
Complainant/Patient Signature Date

OR

_____ _____
Complainant's/Patient's Representative and Relationship Date

*Date of birth is needed to positively establish the identity of the patient

(17I-20 Rev. 02/2008)