BRIAN SANDOVAL
Governor
DAVID G. ROVETTI, DC
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BENJAMIN LURIE, DC
Vice President
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Secretary-Treasurer

STATE OF NEVADA

LAWRENCE DAVIS, DC
Member
TRACY DiFILLIPPO, ESQ
Consumer Member
SHELL MERCER, ESQ
Consumer Member
ANNETTE ZARO, DC
Member

CINDY WADE
Executive Director

CHIROPRACTIC PHYSICIANS' BOARD OF NEVADA
4600 Kietzke Lane, M-245
Reno, Nevada 89502-5000
Fax (775) 688-1920
Telephone (775) 688-1921
Website: http://chirobd.nv.gov
Email: chirobd@chirobd.nv.gov

Dear Sir or Madam:

To file a complaint with this board please complete and submit to this office at the above address the following complaint form and authorization to release information. **The complaint will not be accepted unless your signature is notarized.**

Most complaints concerning fee disputes and/or billing procedures are not within this board's purview. If it is determined that your complaint is not valid or does not enter this board's jurisdiction you should receive written advice within thirty (**30**) days of our receipt of the complaint.

If the Board determines that your complaint is well founded, you may expect to be contacted pursuant to the complaint by a designated member of the Board.

Sincerely,

Cindy Wade
Executive Director

CHIROPRACTIC PHYSICIANS' BOARD OF NEVADA

4600 Kietzke Lane, Suite M-245, Reno, NV 89502 – 775-688-1919

COMPLAINT FORM (Please Type or Print)

Name and address of the chiropractor against whom you are filing this complaint:

_____
_____
_____

Name, address and phone number of person filing this complaint:

_____
_____
_____

Day phone: _____ Eve: _____

Describe your complaint, including dates and locations. Please provide as much detail as possible with regard to the conduct or actions of the chiropractor that form the basis of your complaint. Also, please describe any harm or injury that you believe resulted from the chiropractor's conduct or actions. Attach any paperwork in support of this complaint. Continue on back if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Names, addresses and phone numbers of witnesses to and/or others who can corroborate the above-described incident:

(1) _____
_____
_____
Phone: _____

(2) _____
_____
_____
Phone: _____

I hereby attest that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature ***Date***

Notary Public:

Subscribed and sworn to before me this
_____ day of _____, 20____

_____
Signature

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any licensed physician, hospital, clinic or health professional or facility to release information from my patient records,

_____(patient's name)

to the Chiropractic Physicians' Board of Nevada, its employees or agents.

I understand that this release is granted subject to the following conditions:

1. This information will be used only in the conduct of authorized responsibilities of the Chiropractic Physicians' Board of Nevada,

2. All information may be released. This includes history, mental or physical condition, diagnosis, prognosis and treatment, laboratory reports, diagnostic imaging and billing data, and

3. This release shall be valid for one year.

_____	_____
Date	Signature of Patient
_____	
Date	Signature of Parent or Guardian (if needed)
_____	_____
Date	Signature of Witness