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COMPLAINT FORM

PLEASE PRINT OR TYPE ALL INFORMATION

Illegible or incomplete complaints will be returned to the complainant for completion.

I. COMPLAINANT'S INFORMATION:

NAME: _____
(First) (Middle Initial) (Last)

ADDRESS: _____

(City) (State) (Zip)

PHONE NUMBERS: DAY _____ EVENING _____

EMAIL: _____

II. PATIENT INFORMATION:

NAME(S) and DATE(S) OF BIRTH OF PATIENT(S) RELATIVE TO THIS COMPLAINT:

III. RX # AND NAME OF MEDICATION APPEARING ON PRESCRIPTION LABELS RELATIVE TO YOUR COMPLAINT:

IV. DATE OF MEDICATION FILLING/DISPENSING PRINTED ON THE PRESCRIPTION LABEL RELATIVE TO YOUR COMPLAINT:

V. IDENTIFY THE PERSON (Pharmacist, Pharmacy Tech, Cashier) and/or BUSINESS (Pharmacy, Hospital, Wholesaler/Distributor, etc) RELATIVE TO YOUR COMPLAINT (NAMES, ADDRESSES, and PHONE NUMBERS):

VI. PLEASE EXPLAIN / DESCRIBE YOUR COMPLAINT IN DETAIL, AND INCLUDE THE NAMES OF INDIVIDUALS AND BUSINESSES INVOLVED:

(USE ADDITONAL PAGES AS NECESSARY)

VII. PLEASE LIST THE REMEDY YOU ARE SEEKING:

VIII. PLEASE INCLUDE COPIES OF DOCUMENTS/EXHIBITS THAT SUPPORT YOUR COMPLAINT (MEDICATION GUIDELINES, PHOTOS, LETTERS, RECEIPTS, ETC).

COPIES PROVIDED: (Initial the correct answer): Yes _____ /or/ No _____

Please note that a copy of this complaint may be provided to the respondent(s) or any other parties to the complaint at any time. Further, your complaint is subject to public disclosure. However, private medical information will be protected to the full extent permitted by law.

Further note that action taken on this complaint may result in a hearing which may require your attendance to testify regarding the issues involved. Therefore, it is imperative that the information provided be true and accurate to the best of your knowledge, and that you cooperate with the investigation. Therefore, the information requested above must be provided.

BY SIGNING BELOW, I SWEAR or AFFIRM THAT ALL INFORMATION PROVIDED IN THIS COMPLAINT IS TRUE AND FACTUAL:

COMPLAINANT'S SIGNATURE

DATE