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.

Email address: _____
Name of person registering the complaint: _____
Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Work phone number: _____ Home phone number: _____
Relationship to patient: _____

Name of pharmacy: _____
Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Name of pharmacist if known: _____
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 code: _____
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 Patient birthdate: _____
Brief description: _____

Did the pharmacist consult with you regarding your medication at the time it was dispensed? ☐ Yes ☐ No
Was any of the medication take or used? ☐ Yes ☐ No
Do you still have the medication/receipt? ☐ Yes ☐ No
Do you still have the container/label/receipt? ☐ Yes ☐ No
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? ☐ Yes ☐ No

IF YOU HAVE THE MEDIACTION AND/OR CONTAINTER, 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 FROM 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 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