MINNESOTA
BOARD OF PHYSICAL THERAPY

335 Randolph Avenue, Suite 285
St. Paul, MN 55102
612.627.5406 (phone) | 651.797.1377 (fax)
physical.therapy@state.mn.us | https://mn.gov/boards/physical-therapy/
MN Relay Service for Hearing Impaired 800.627.3539 (phone)

COMPLAINT REGISTRATION FORM

INFORMATION & INSTRUCTIONS

INSTRUCTIONS

Please provide as much information as possible on pages 2-6 of this form and send them to the Board's office or email to the Board at physical.therapy@state.mn.us . If you have additional documents, records, or evidence to support your complaint, please include that information for the Board's review.

BOARD AUTHORITY

The Board of Physical Therapy has jurisdiction over individuals licensed by the Board. These include:

- Physical Therapists
- Physical Therapist Assistants

The Board also has the authority to investigate the alleged unlawful practice of the professions listed above.

Please note that the Board is unable to investigate complaints regarding other health professionals who are not licensed by the Board, The Board also does not have jurisdiction over hospitals, clinics, or other healthcare facilities. Additionally, we are unable to assist patients with billing disputes.

NOTICE OF RIGHTS UNDER THE MINNESOTA GOVERNMENT DATA PRACTICE ACT

I understand that I am not legally required to complete or return this form. It is offered so that the Board may properly and thoroughly evaluate and investigate this complaint and, if necessary, submit this information in any legal proceeding. Recognizing the Board's need to verify and, if necessary, legally pursue this complaint, I authorize the Board, its agents, and/or agents of the Attorney General's Office representing the Board to disclose this information to those whom they reasonably believe have a need to know.

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YOUR CONTACT INFORMATION

FIRST NAME:	LAST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	EMAIL ADDRESS:	

Who is submitting this complaint? *Check all that apply*:

- ☐ A patient
- ☐ A Board of Physical Therapy licensee
- ☐ A friend or family member of a patient
- ☐ A licensee of another board
- ☐ Other:

PROVIDER'S INFORMATION YOU ARE REPORTING

Please list the provider you are complaining about. You can find information on any provider licensed by our board by visiting our website and using the "Verifying a License" tab.

FIRST NAME:	LAST NAME:	
LICENSE TYPE: ☐ Physical Therapist ☐ Physical Therapist Assistant	LICENSE NUMBER, if known: PHONE NUMBER:	
NAME OF EMPLOYER/HOSPITAL/CLINIC:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:

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STATEMENT OF COMPLAINT

Patient Name:	Patient Date of Birth:	Relationship to Patient:

Name & Address of Hospital or Clinic, etc., Where Conduct/Care Occurred:

Date When Conduct/Care Occurred:

Describe What Happened (You may attach additional pages if you like)

ACKNOWLEDGMENT & SIGNATURE

I attest all information provided in this Complaint Form is true and correct to the best of my knowledge.

Signature:	**Date:**

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STATEMENT OF COMPLAINT (continued)

ACKNOWLEGEMENT & SIGNATURE

I attest all information provided in this Complaint Form is true and correct to the best of my knowledge.

Signature:	**Date:**

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MEDICAL INFORMATION RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH DATA

To: Any Privacy Officer/Health Care Professional

Having been informed of my rights under the Minnesota Government Data Practices Act, I authorize you to furnish a copy of my records in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Physical Therapy, its agents, agents of the Attorney General's Office representing the Board, and any other appropriate state or federal governmental agencies as allowed by law.

I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records and authorize the Board to use the information you provide along with the records in any legal proceeding which may arise out of this matter.

I release you, the Minnesota Board of Physical Therapy, its agents and the agents of the Attorney General's Office representing the Board from Liability for so releasing said records or so testifying, and waive any privileges afforded me by the law relating to disclosure or introduction into evidence of this health information.

A photocopy of this form is as valid as the original.

Print or Type Patient's Full Name:	**Patient's Date of Birth:**
Address of Patient or Patient's Legal Representative:	
Signature of Patient or Patient's Legal Representative:	**Today's Date:**

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AUTHORIZATION TO INFORM PHYSICAL THERAPIST/PHYSICAL THERAPIST ASSISTANT OF COMPLAINT

Having been informed of my rights under Data Practices Act, I, _____, hereby authorize the Minnesota Board of Physical Therapy, its agents, or the agents of the Minnesota Office of Attorney General, to inform _____ of my complaint by providing this physical therapist or physical therapist assistant copies of my complaint documents.

_____ _____

Signature of Complainant Date

Mail, Fax or Email these forms to:

Minnesota Board of Physical Therapy

335 Randolph Avenue, Suite 285

St. Paul, MN 55102

Fax: (651) 797-1377

Email: physical.therapy@state.mn.us