MINNESOTA
BOARD OF PHARMACY

Pharmacy-Related Complaint Registration

Please read all instructions carefully prior to completing the complaint form. If the form is not properly completed and signed, it will be returned for correction.

Instructions: you may use this form to file a complaint against a pharmacist, pharmacy technician, pharmacy intern, pharmacy, drug manufacturer, wholesaler, or distributor. The information you provide will be evaluated to determine whether the Board will take action. Failing to provide the Board with your identity may prohibit the Board from investigating alleged violations adequately, and we will not be able to provide you with status updates. Per Minnesota statutes, the identity of a complainant and information submitted in support of a complaint are defined as non-public, private, or confidential data.

Complainant's Name:_____

Phone number: _____Email address*: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

*If you would like to receive notifications concerning this complaint electronically at the email listed, check the "yes" option below. If you prefer to receive notification through US Mail, check the "no" option.

◯ **Yes, email notifications can be sent electronically at the email address listed above. By checking "yes" you are waiving your right to confidentiality for the limited purpose of exchanging such data with the Board via your personal, unsecured, email address.**

◯ **No, I wish to receive written notifications.**

Subject of Complaint (pharmacy/pharmacist, etc.)**:** _____

Date/time of Incident: _____ Phone number: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Prescription information: (attach additional documents as necessary)

Name of Patient: _____ Drug name(s)/Strength: _____

Patient Date of Birth: _____ Prescription #: _____ Fill Date: _____

Doctor's Name: _____ Doctor's Phone: _____

Statement of Complaint: (attach additional photos/documents as necessary to support the complaint)

I understand that pursuant to the Minnesota Data Privacy Act, the information submitted in this form is non-public, confidential information. This information which I am not legally required to submit, 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. The Board will not release this information unless it is required to do so as part of a legal proceeding and then only in compliance with applicable laws. The Board will share this information with the Office of the Attorney General, which may help the Board investigate the complaint and which services as the Board's legal counsel.

I attest all information provided in this complaint form is true and correct to the best of my knowledge. If submitted electronically, entry of a typed name will constitute my signature.

Signature is Required.

Signature: _____ Date: _____

Mail, Fax, or Email this form to:

Minnesota Board of Pharmacy
335 Randolph Avenue, Suite 230
St. Paul, MN 55102
Fax: (651) 215-0951
Email: pharmacy.board@state.mn.us