APCA™
Alliance for Physician Certification & Advancement

COMPLAINT FORM

This form is to be used to report a violation of APCA Compliance Policies.

Please provide as much information in the form below as possible to assist the APCA in the investigation of the matter you are reporting. All complaints submitted to the APCA will remain confidential. The APCA accepts anonymous complaints, however without a point of contact for clarification of the circumstances noted in the complaint, the ability to move forward with an investigation may be limited.

SUBJECT OF COMPLAINT

Name: ____
First M.I. Last

Home Address: ____
Street City State Zip Code

Place of Employment: ____

Job Title: ____

Address: ____

Home Phone: ____________________Work Phone: ____________________ E-mail: ________________

APCA Certification Number: __________________________ Date of Birth: __________________________

Is this person licensed? Y/N (circle one)

If yes, please provide the following information:

- Type of license(s) held: ____

  ____

- License number(s) (if known) and state where license was issued: ______________________________

  ____

  ____

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COMPLAINT FILED BY:

Name:

____
First M.I. Last

Address:

____
Street City State Zip Code

Organization/Facility Name (If Applicable): ____

Home Phone: ________________Work Phone: ________________ Cell Phone: _________________

E-mail: ____

Relationship to Subject of Complaint: ____

WAS LAW ENFORCEMENT CONTACTED? Y/N (circle one)

If yes, please provide the following information:

- Date matter was reported: ____
- Name of law enforcement agency and point of contact:______________________________________

  ____
- Address, telephone number and e-mail address of law enforcement agency and/or agency point of contact:

  ____

  ____

WAS THIS MATTER REPORTED TO ANY OTHER INDIVIDUAL/AGENCY? Y/N (circle one)

If yes, please provide:

- Name of individual/agency: ____
- Address: ____
- Telephone number and e-mail address (if applicable): _______________________________________

- Status/outcome of complaint: ____

DID THE VIOLATION INVOLVE A PATIENT? Y/N (circle one)

If yes, please provide patient's information below: Name:

____

First M.I. Last

Address:

____

Street City State Zip Code

Home Phone: ______________________ Work Phone: ________________________

Cell Phone: _______________________ E-mail: ____________________________

PLEASE STATE YOUR RELATIONSHIP TO THE PATIENT

☐ Self ☐ Spouse ☐ Family Member (please specify) ____________________

☐ Practitioner ☐ Law Enforcement ☐ Other (please specify) ____________________________

WITNESSES

Name:_____________________________Address: ____

Phone Number: _______________________ E-Mail: ____

Relationship to Subject of Complaint: ____

Relationship to Patient (if applicable): ____

Name:_____________________________Address: ____

Phone Number: _________________________ E-Mail: _____________________________________

Relationship to Subject of Complaint: ____

Relationship to Patient (if applicable): ____

Name:_____________________________Address: ____

Phone Number: _________________________ E-Mail: ______________________________________

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Relationship to Subject of Complaint: ______________________________

Relationship to Patient (if applicable): ______________________________

SUMMARY OF COMPLAINT

Please provide a legible statement providing the full details of your complaint, including a detailed description of the circumstances. Be sure to include dates, locations, names and attach copies of documentation that will support your complaint. If necessary, you may attach a separate sheet of paper to continue your statement.

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1401 Rockville Pike, Suite 600, Rockville, MD 20852-1402 | Toll Free: 800-943-1709 | Local: 240-386-1738 | Fax: 301-424-2095 | APCA.org

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By signing this document, you are attesting that all the information is true and without malice. If the allegations in your complaint are determined to be possible violations of the Compliance Policies, an investigation will be opened. As a reminder, all complaints submitted to the APCA will remain confidential. The APCA accepts anonymous complaints however without a point of contact for clarification of the circumstances noted in the complaint, the ability to move forward with an investigation may be limited.

Signature: ______________________________ Date: ____________________

COMPLAINT SUBMISSION

Please submit your complaint by one of the following methods: Mail

Alliance for Physician Certification & Advancement (APCA)
Attention: Compliance Department
1401 Rockville Pike, Suite 600
Rockville, MD 20852-1402

E-mail: Compliance@APCA.org

Fax:
301-560-6679

For questions regarding the APCA Compliance Policies or the complaint process, please contact the Compliance Department at (800) 943-1709.