



Physical Therapy Board of California

Consumer Protection Services Program

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Internet: www.ptb.ca.gov Email: cps@dca.ca.gov

CONSUMER COMPLAINT FORM

Print or Type

Person Registering the Complaint

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> First Name:	M.I.:	Last Name:
Street Address:		
City:	State:	Zip Code:
Home Telephone Number: ()	Mobile Telephone Number (optional): ()	
Work Telephone Number: ()	E-Mail Address (optional):	
Patient's Full Name:		
Patient's Date of Birth: (month / day/year)		
Your Relationship to the Patient:		

I wish to submit a complaint about the individual named below. I understand that the Physical Therapy Board of California cannot seek restitution for damages, not provide legal advice, or assist with lawsuits. However, I am submitting this information so that the Board determine whether disciplinary action should be taken against the practioner's license.

Complaint is Registered Against

Check One: <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Physical Therapist Assistant <input type="checkbox"/> Physical Therapy Aide <input type="checkbox"/> Other		
First Name:	M.I.:	Last Name:
License No. (if known):		
Office/Facility Name:		
Street Address:		
City:	State:	Zip Code:
Telephone Number: ()		
Has the patient been examined/treated by another professional for this same condition? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, provide name and address on Authorization for Release of Medical Information		
Reason for Treatment:		
Date(s) of Treatment:		

