Complaint Management Board of VERITAS

+94 71 218 2222 veritascosmetic.com contact@veritascosmetic.com
398, Peradeniya rd, Kandy

OFFICE USE ONLY:
Entered into Database (date) _____/_____/_____ Complaint # _____ Initials _____

Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.

COMPLAINANT

☐Mr.
☐Mrs.
☐Ms. _____ _____ _____
Your Last Name | Your First Name | Patient's Name (If different)

Your Business Name: _____
(if applicable)
Business Address: _____ _____ _____ _____
Street | City | State | Zip

Your Address: _____ _____ _____ _____
Street | City | State | Zip

Your Primary Phone number: ( ) Your Secondary Phone number: ( ) Your Email:

LICENSEE

DO NOT LIST A DENTAL CLINIC OR DENTAL CENTER ON THIS LINE

☐ DENTIST ☐ DENTAL ASSISTANT ☐ DENTAL HYGIENIST

_____ _____ _____
Last Name | First Name | Lic # (if known)

Clinic Name: _____

Clinic Address: _____ _____ _____ _____ _____
Street | City | State | Zip | Phone

COMPLAINT DETAILS

PREVIOUS DENTIST (if applicable) _____
Name

_____ _____
Street and City Address | Phone

SUBSEQUENT DENTIST* (if applicable) _____
Name

_____ _____
Street and City Address | Phone

* Attach report from subsequent dentist (if available).

Have you discussed this matter with the dentist/hygienist/dental assistant or anyone in the licensee's office? ☐ Yes ☐ no

Date of contact: _____ How was contact made? (Phone, e-mail, letter, in person)
_____

Result of contact _____

Witness name(s) and telephone number(s) (if applicable) _____

Have you filed this complaint with any other state agencies? _____ If yes, explain _____

_____

Are you willing to testify in person regarding this matter at a formal hearing? ☐ Yes, I am willing. ☐ No, I am not willing.

What action by the Board would address your complaint? _____

COMPLAINT DESCRIPTION

NATURE OF COMPLAINT:

- ☐ Misdiagnosis of condition
- ☐ Patient abandonment/neglect
- ☐ Inferior Treatment - Quality of care provided
- ☐ Unable to obtain dental records or x-rays
- ☐ Inappropriate prescribing
- ☐ Fraud
- ☐ Business practice Issues
- ☐ Impairment
- ☐ Unlicensed practice
- ☐ Other (specify)

DATE(S) OF INCIDENT(S): _____

DETAILS OF COMPLAINT: Clearly describe the incident(s) leading up to your complaint. If applicable, **attach copies** of documents such as medical and/or dental records, photographs, bills, insurance statements, cancelled checks, correspondence, prescriptions, witness statements, etc. that support your statements. DO NOT SEND ORIGINALS. Attach extra paper as needed to complete this section.

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AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature on this form, or photocopy thereof, authorizes the Veritas Dental Lounge to: (1) receive copies of all my health records relating to my complaint; (2) to share the complaint and all records collected by the Veritas Dental Lounge during the investigation of my complaint with the use in responding to the allegations in this complaint; and (3) to refer my complaint to other regulatory and/or law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis.

The act of filing a complaint and its receipt and/or investigation by Complaint Management Board of Veritas does not mean that disciplinary action will be taken against the complaint.

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of
☐**Patient or**
☐**Legal Representative**
(attach documentation)

Date

Mail this form to:
Complaint Management Board
Veritas
398, Peradeniya rd, Kandy
Sri lanka

E-Mail this form to:
contact@veritascosmetic.com

OFFICE USE ONLY:

_____ _____

Signature of Executive Director or Designated Board Representative **Date**