STATE BOARD OF PHARMACY
800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

REGISTRATION APPLICATION: Complaint Form

Form C-100

INSTRUCTIONS

Please submit as much information as possible when submitting your Complaint Form. The more information we have, the better the Investigative Report can be compiled.

If you cannot be reached during the day, then please give us an evening phone number and a time to reach you. It might be necessary to verify information with you during the course of our investigation.

PROCESS

Once we have received your Complaint Form, the following takes place:
1. We notify you that your complaint has been received.
2. The Executive Secretary reviews the complaint and assigns an appropriate investigator.
3. A Board inspector conducts an investigation to compile a report that is presented to the Board.
4. The Investigative Member of the Board reviews the Investigative Report to determine if any possible violations of the Kansas Law have occurred.
5. The Board determines if a hearing is warranted and notifies the appropriate parties.

If possible violations are indicated in the Board's opinion, then a hearing with the licensee is arranged according to the Kansas Administrative Procedure Act. The hearing is to give the licensee an opportunity to present his/her case. There is a possibility that you and the appropriate other parties will need to appear at the hearing, but this is not always the case. You will be given ample advance notice should we request your presence.
The Board meets quarterly and consists of seven Governor-appointed members serving four-year terms. Six members are registered pharmacists and one is a consumer. The Board has the legal authority to revoke, suspend, or restrict the licenses that they regulate. The Board also has the authority to impose monetary fines.

JURISDICTION AND SCOPE OF AUTHORITY

The Board does not have the authority to regulate the manner in which prices are charged by pharmacies or complaints about insurance or other billing matters. Complaints dealing with these matters should be filed with the Consumer Protection Division of the Kansas Attorney General's Office (120 SW 10th, Topeka, Kansas 66612-1597).

Additionally, the Board does not regulate prescribers or other healing arts or nursing professionals.

INFORMATION

Name of Person Registering Complaint			
Permanent Mailing Address			
City	State	Zip	County
Home Phone	Cell Phone		Email
Name of Patient		Patient Date of Birth	Relationship to Patient
Name of Pharmacy			
Address of Pharmacy			
City	State	Zip	County
Name of Pharmacist (if known)		Name of any other person involved	
When did the problem occur?			

Revised 05/16

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DETAILS OF COMPLAINT Describe the events in the order they happened as completely as possible. (Use extra sheets if necessary.)

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ACTION TAKEN

☐ Yes ☐ No **Have you discussed the matter with the pharmacist?**		
Name of person contacted	Date of contact	
How was contact made? ☐ By Phone ☐ By Letter/Email ☐ In Person		

FURTHER INFORMATION

Complete only if applicable

Prescribing Doctor	Telephone Number		
Address of Doctor	City	State	Zip Code
Medication prescribed	Medication Received	Prescription Number	
The prescription was: ☐ for a new prescription ☐ a refill ☐ a new prescription for a medication taken or used previously			
☐ Yes ☐ No Was there harm to the patient? If yes, describe briefly:			
☐ Yes ☐ No Was counseling offered by the pharmacy/pharmacist?			
☐ Yes ☐ No Was counseling declined by the patient?			
☐ Yes ☐ No Was the counseling provided by the pharmacist?			
☐ Yes ☐ No Was counseling provided by another individual? If so, who?			
☐ Yes ☐ No Was any of the medication taken or used?			
☐ Yes ☐ No Do you still have the medication?			
☐ Yes ☐ No Do you still have the container/label? **If you have the medication and/or container, please retain them until further notified by the board inspector.**			
If this complaint is against an individual licensed by the Board of Pharmacy, would you be willing to testify against the individual? ☐ Yes, I will be willing to testify. ☐ No, I would not be willing to testify.			

If applicable, please attach to this form <u>COPIES</u> of any papers involved (prescription, bill/invoices received, cancelled checks, correspondence, etc.) Do NOT send originals.

OUTCOME

What outcome would you like to see as a result of this complaint?

VERIFICATON

The information contained in this form is true, correct, and complete to the best of my knowledge.

SIGNATURE

DATE SIGNED

Revised 05/16