State Board of Optometry

4815 W. Markham St., Slot 70
Little Rock, AR 72205
Phone: (501) 534-6139
Fax: (501) 534-6026
www.aroptometry.org
ADH.OptometryBoard@arkansas.gov

FOR BOARD
USE ONLY:
Date Received:
_____

Complaint Form

Return the completed forms via mail to the Board office address or via email to the Board email address. You will be notified if additional information is needed and/or after the optometrist has responded.

Complainant Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Patient Name (if different): _____ Patient Date of Birth: _____

Optometrist Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date(s) of Visit: _____

Statement of your Complaint (use additional pages if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

Date: _____ Signature: _____

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Authorization to Release Complaint Information

I hereby give the Arkansas State Board of Optometry permission to send a copy of my complaint to the optometrist listed below. This will include disclosing my identity.

I may elect to not sign below and thus request my identity be kept confidential. A summary of the complaint will be provided to the optometrist, but it will not include my name. I understand that even if I do not sign below and have the Board investigate this complaint confidentially, the Board may be required by law to disclose my identity to the optometrist at a later as the investigation continues.

Understanding the above, by my signature below, I hereby give consent to the Board to release a copy of my complaint to the optometrist.

Optometrist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Complainant (print name): _____

Complainant Signature: _____ Date: _____