KANSAS DENTAL BOARD
Landon State Office Building
900 SW Jackson, Room 564-S
Topeka Kansas 66612
Phone 785-296-6400
Fax 785-296-3116

INSTRUCTIONS

To file a complaint, please state clearly and specifically, all allegations against the person named below. **List each incident, specific date(s), full name of the patient, and a brief statement describing each incident.** If additional space is required, please attach additional pages. Attach copies of any documents you have concerning the allegation. In order for the board to fully investigate, both sides of the form must be completed. ***PLEASE ATTACH ANY ADDITIONAL INFORMATION YOU FEEL IS NECESSARY.

PLEASE TYPE OR PRINT

PERSON MAKING ALLEGATION: NAME_____

ADDRESS_____
Street City State Zip

HOME PHONE_____DAY TIME PHONE_____

PATIENT NAME _____ DATE OF BIRTH_____

PERSON AGAINST WHOM THE ALLEGATION IS MADE:

NAME_____
(Indicate Profession – Dentist or Dental Hygienist)

ADDRESS_____
Street City State Zip

I agree to testify in any hearings, which may arise as a result of this allegation. The statements I have made are true and correct to the best of my knowledge and belief.

DATE _____ SIGNATURE_____