KENTUCKY BOARD OF PHARMACY

State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910
Fax (502) 696-3806
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http://pharmacy.ky.gov

COMPLAINT

Person Making Complaint:	Date:
Home Address:	Home Phone:
	Work Phone:
Person involved in complaint (if different than person making complaint):	

Name of Patient:	Drug name/strength:	Drug amount:
Prescription #:		Date of fill or refill:
Doctor's name:		Doctor's phone:

Name of pharmacist (if known):	
Name of pharmacy:	Pharmacy phone:
Pharmacy address:	

Please explain complaint (attach separate sheet if necessary):

I swear or affirm that all information contained on and with this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

IMPORTANT: Please submit any applicable evidence such as vials, medications, receipts, etc. with this complaint.