Oklahoma State Board of Medical Licensure & Supervision

Death Certificate Complaint

Date _____

Complainant: _____ Address: _____

Contact Phone/e-mail: _____fax: _____

Licensee: _____ Contact info: _____

Name of Deceased: _____ DOB:_____ DOD:_____

Place of death: _____ Attended____ or unattended____ M.E. info. (released by ME if unattended, etc.)

_____

Please provide complete details of when, where, how and by whom the DC was delivered to physician. Explain who has been contacted and the result (name, date, contact info., response, etc.)

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Upon resolution, by what means would you like the DC returned to you? (mail, pick it up in person, etc.) _____

DISPOSITION: (DO NOT COMPLETE – for office use only)

(initial & date) (note)

_____Not Opened_____

_____Hold pending receipt of additional info _____

_____Open _____

_____Other _____