ARIZONA STATE BOARD OF PHARMACY
P. O. Box 18520 Phoenix, AZ 85005
p) 602-771-2727 f) 602-771-2749 www.azpharmacy.gov

CONSUMER COMPLAINT FORM

COMPLAINANT INFORMATION

Name: ______________________ Daytime Phone: __________

Address: ______________________ ______________________ __________ __________

Street and Number | City | State | Zip

PHARMACY INVOLVED

Pharmacy Name: ______________________ Phone: __________

Address: ______________________ ______________________ __________ __________

Street and Number | City | State | Zip

Prescription: ______________________ __________

Number | Date

______________________ ______________________

Patient Name | Medication Name

Pharmacist (if known): ______________________

Physician Name: ______________________ Phone: __________

BRIEFLY OUTLINE ACTIVITIES LEADING TO THIS COMPLAINT (750 char limit)

If complaint involves a prescription error, is the evidence available? ☐ YES ☐ NO

If YES, where is evidence? ______________________

Has the pharmacist been contacted? ☐ YES ☐ NO

If YES, what was the result? ______________________

If NO, why wasn't contact made? ______________________

Has the physician been contacted? ☐ YES ☐ NO

If YES, what was the result? ______________________

If NO, why wasn't contact made? ______________________

Your Signature: ______________________ Date: __________