Complaint Referral Form
Medical Assistant Program

5500 South Zapata Highway, Laredo, TX 78046
Phone: 956-721-5261 Fax: 956-721-5431
Email: ma@laredo.edu

Complaint Against

Name: _____

☐ MA Program ☐ Program Faculty ☐ MA Student ☐ MA Graduate

Person Filing Complaint (*Required)

Name: _____

☐ Physician ☐ Clinical Instructor ☐ Employer ☐ Patient ☐ Patient Family Member

☐ Other

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email: _____

Detail of Complaint

Signature _____ Date: _____

The completed form can be emailed or mailed to the address listed at the top.

***Neither the Board nor any College employee shall unlawfully retaliate against any member of the general public for bringing a concern or complaint.**