Return form to mmaiden@akdental.org or mail to ADS, 1407 W. 31st Ave, Suite 304, Anchorage, AK 99503

PATIENT REQUEST FOR MEDIATION

PEER REVIEW is neither a court of law, an adversary proceeding, nor a punitive action hearing. It is an informal arena in which a problem or dispute can be resolved through either mediation by one member of the committee or a full-panel proceeding - examination of the patient and separate interviews with the patient and the dentist providing the treatment. When the Alaska Dental Society has received back this completed form, the peer review committee is notified and the patient will be contacted by a member of the committee. Unless directed otherwise, mediation will be scheduled first. If the patient does not feel mediation would be useful, arbitration (examination and interviews) will be scheduled.

PATIENT INFORMATION:

Date: / /

Name: Phone:

Address:

City: State: Zip:

DENTIST INFORMATION:

Name:

Address: Phone:

City: State: Zip:

Date of last appointment: _____

Please describe the problem(s) specific to the dental treatment received and as best you can, try to recall dates:

_____

_____

Please provide a phone number and the best time of day the mediator will be able to contact you. If you have any questions, please call the Alaska Dental Society office at 907-563-3003.

Day phone: Time:

Evening Phone: Time:

In order for a complete review to be performed, I agree to the following:

1. I understand that the elapsed time between treatment, or the discovery of the incident in question, and filing a complaint may not be more than five years.
2. I have not contacted an attorney pertaining to my complaint.
3. I understand that I cannot be refunded for any monies beyond that which I have paid to the dentist for whom I have made my complaint.

Signature