

## COMPLAINT FORM

**(NOTE: Do not use this form for complaints against a Direct Entry Midwife – See Direct Entry Midwifery Complaint Form)**

If you are using any Apple product (Mac, iPad, iPhone), please download and use Adobe Reader before completing this form.

### SELECT REGULATED PROFESSION:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ART THERAPISTS   | <input type="checkbox"/> DENTURE TECHNOLOGISTS            | <input type="checkbox"/> LONG TERM CARE ADMINISTRATORS  |
| <input type="checkbox"/> ATHLETIC TRAINERS  | <input type="checkbox"/> ELECTROLOGISTS                   | <input type="checkbox"/> MUSIC THERAPISTS               |
| <input type="checkbox"/> BEHAVIOR ANALYSTS  | <input type="checkbox"/> ENVIRONMENTAL HEALTH SPECIALISTS | <input type="checkbox"/> POLYSOMNOGRAPHIC TECHNOLOGISTS |
| <input type="checkbox"/> BODY ART (body piercers, tattoo artists)   | <input type="checkbox"/> HEARING AID DEALERS              | <input type="checkbox"/> RESPIRATORY THERAPISTS         |
| <input type="checkbox"/> CERTIFIED ADVANCED ESTHETICIANS  | <input type="checkbox"/> LACTATION CONSULTANTS            | <input type="checkbox"/> SEXUAL OFFENSE THERAPISTS      |
| <input type="checkbox"/> COSMETOLOGISTS (barber, standard esthetician, hair design, nail tech, natural hair care) | <input type="checkbox"/> LICENSED DIETITIANS              | <input type="checkbox"/> WASTE WATER SPECIALISTS        |

### Complaint Against:

NAME OF BUSINESS		
NAME OF INDIVIDUAL		LICENSE NUMBER (if known)
STREET ADDRESS		
CITY		STATE
		ZIP
ADDITIONAL LOCATION INFORMATION (if any)		DATE OF INCIDENT
HOME PHONE	BUSINESS PHONE	CELL PHONE
EMAIL ADDRESS (if applicable)		WEB ADDRESS (if applicable)

### Person Filing Complaint:

NAME		DATE
PHYSICAL ADDRESS		
CITY		STATE
		ZIP
MAILING ADDRESS		
CITY		STATE
		ZIP
HOME PHONE	BUSINESS PHONE	CELL PHONE
EMAIL ADDRESS (if applicable)		WEB ADDRESS (if applicable)

### For Denture Complaints Only: (If this is not a denture complaint, skip this section and move to the next page)

Is this complaint specific to a denture or set of dentures? Yes  No  (If no, move on to the next page)

If your answer to the question above is yes, have the denture(s) been adjusted, worked on, or tampered with in any way since you initially received them? Yes  No  (If no, move on to the next page)

If your answer to the question above is yes, please provide the name and contact information of the person(s) who adjusted or worked on the denture(s):

**Nature / Description of Complaint / Affected Person(s):** (attach additional pages if necessary)

**Complainant's Signature:**

**Date:**

The Health Licensing Office has no authority to require licensees to refund money to their clients. The office only has authority to investigate and take action when violation of Oregon Revised Statutes or Oregon Administrative Rules is proven.