

FOR BOARD USE ONLY: COMPLAINT # _____ RECEIVED _____

STATE OF MONTANA
BOARD OF HEARING AID DISPENSERS
MONTANA DEPARTMENT OF LABOR AND INDUSTRY, 301 SOUTH PARK, P O BOX 200513
HELENA, MT 59620-0513
(406) 841-2395

COMPLAINT FORM

Please print or type **COMPLAINANT INFORMATION**

NAME	ADDRESS	AGE
CITY	STATE	ZIP
	HOME PHONE	WORK PHONE

COMPLAINT REGISTERED AGAINST

DISPENSER'S NAME	COMPANY NAME	BUSINESS PHONE
COMPANY ADDRESS	CITY	STATE
		ZIP

PLEASE ANSWER THE FOLLOWING QUESTIONS:

INITIAL CONTACT: DISPENSER CONTACTED ME: _____
I CONTACTED DISPENSER : _____
DISPENSER CAME TO MY HOME : _____
I WENT TO DISPENSERS' OFFICE: _____

If Dispenser came to your home, did the Dispenser give you a form, separate from the contract, to mail back if you decided to cancel the contract within 3 working days? Yes _____ No _____

Did you send this form back? Yes _____ No _____

If so, what date _____

WAS THE DISPENSER LICENSED? _____

WAS THE DISPENSER A TRAINEE? _____

If the dispenser was a trainee, was a licensed dispenser with the trainee? YES _____ NO _____

What was the trainee's name? _____

CONTRACT: DATE CONTRACT SIGNED : _____

(PLEASE ATTACH A COPY OF THE CONTRACT)

COMPLAINT # _____ IN RE: _____

MEDICAL EVALUATION: DID DISPENSER ADVISE YOU THAT A MEDICAL EVALUATION BY A PHYSICIAN WOULD BE IN YOUR BEST INTEREST?
Yes _____ No _____

Were you examined by a physician? Yes _____ No _____

If so, what date _____

Physician's name _____ Phone #(_____) _____

Address _____

I give my permission to the above named physician to release pertinent medical records to the Board of Hearing Aid Dispensers.

Signature _____

HEARING AIDS: DELIVERY DATE: _____

I AM STILL IN POSSESSION OF THE HEARING AID(S) YES _____ NO _____

NOTIFIED DISPENSER OF PROBLEM:

DATE OF FIRST NOTIFICATION _____

Notification was made in writing _____

Notification was made by phone _____

Notification was made in office _____

REFUND REQUESTED:

DATE REFUND WAS FIRST REQUESTED: _____

Request was made in writing _____

Request was made by phone _____

Request was made in office _____

AID(S) WERE RETURNED FOR REFUND: YES _____ NO _____

WHAT DATE? _____

By mail _____

In person _____

REFUND HAS BEEN RECEIVED YES _____ NO _____

DATE RECEIVED _____

DESCRIPTION OF COMPLAINT

Please describe alleged action, denial of service, misrepresentation and other information expressed in your own words. Give names, dates, places, action/events, witnesses and other pertinent information.

COMPLAINT # _____ IN RE: _____

SPECIFY CORRECTIVE ACTION YOU ARE SEEKING :

PLEASE ATTACH COPIES OF ANY WRITTEN CORRESPONDENCE YOU HAVE HAD WITH THE DISPENSER.

PLEASE LIST DATES YOU HAVE CALLED THE DISPENSER OR DATES THE DISPENSER HAS BEEN TO YOUR HOME OR YOU HAVE BEEN TO THE DISPENSER'S OFFICE.

PLEASE LIST DATES THE HEARING AIDS HAVE BEEN OUT OF YOUR POSSESSION FOR REPAIR OR REMAKE SINCE THE DATE OF DELIVERY.

I HEREBY AUTHORIZE ANYONE WHO HAS INFORMATION PERTINENT TO THE INVESTIGATION OF THIS COMPLAINT TO RELEASE THAT INFORMATION TO A REPRESENTATIVE OF THE MONTANA BOARD OF HEARING AID DISPENSERS.

SIGNATURE _____ DATE _____

I HEREBY SWEAR THAT THE INFORMATION GIVEN IN THIS COMPLAINT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

July 14, 2000