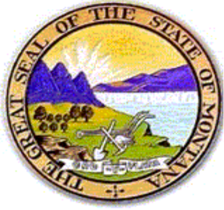

STATE OF MONTANA
DEPARTMENT OF LABOR AND INDUSTRY
HEALTH CARE LICENSING BUREAU
301 S PARK, 4th FLOOR
PO BOX 200513
HELENA, MONTANA, 59620-0513
Phone: (406) 841-2300 Fax: (406) 841-2363

FOR COMPLIANCE USE ONLY

Complaint # ________________

Date Received: ______________

COMPLAINT AGAINST: ______________________ LICENSE #: ______________

PROFESSION / OCCUPATION TYPE: ______________________________

BUSINESSES: ______________________________

ADDRESS: ______________________ ____________ / ________ ____________
Street or PO Box City State Zip Code

If Applicable:
PATIENT NAME: ______________________________

NATURE OF COMPLAINT: Please describe in detail the nature of the complaint, giving dates and other information. If service is part of the complaint, give information about telephone calls, contracts, etc. Attach additional sheet(s), if necessary. (Maximum characters: 950)

LIST OF WITNESSES AND EVIDENCE:

WHAT ACTION ARE YOU REQUESTING OF THE BOARD OR DEPARTMENT?

YOUR NAME *(complainant)*: ______________________ **PHONE#**: ______________
Please Print

YOUR ADDRESS *(complainant)*: ______________ ______________ ______________
Street or PO Box City/State Zip Code

YOUR SIGNATURE: ______________________ **DATE:** ______________

I hereby authorize that all of my protected health information maintained by any and all of my healthcare providers and that all of my health information maintained by any and all of my healthcare providers be furnished to the above-named licensing board and/or its agents. This authorization shall remain in effect until the licensing board has concluded all actions concerning this complaint.

COMPLAINANT'S SIGNATURE: ______________________ DATE: ______________