DEPARTMENT OF HEALTH

Complaint Form

Health Occupations Program

Tennessen Warning

MINNESOTA GOVERNMENT DATA PRACTICES ACT NOTICE: The Health Occupations Program in the Minnesota Department of Health (MDH) is asking for information (data) about your complaint. The data you provide is voluntary. MDH will use the data to investigate your complaint. According to the Government Data Practices Act, information gathered during the investigation is confidential. By completing and signing this document, you authorize MDH, its agents, and/or agents of the Attorney General's Office representing MDH to disclose the data to whom they reasonably believe need to know. MDH may use the data in legal proceedings. After the investigation is closed, MDH classifies the investigative data as private data pursuant to Minnesota Statute 13.41. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

Consent Form

The Minnesota Department of Health asks that you print and complete the Minnesota Standard Consent Form to Release Health Information (http://www.health.state.mn.us/divs/hpsc/dap/consent.pdf) and the complaint form provided below and mail both completed forms via U.S. Mail to:

Minnesota Department of Health
Health Occupations Program
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Please type or print clearly, blue ink preferred.

This complaint refers to which type of practitioner?

☐ Audiologist
☐ Body Art Technician or Establishment
☐ Hearing Instrument Dispenser
☐ Occupational Therapist
☐ Occupational Therapy Assistant
☐ Speech Language Pathologist
☐ Unlicensed Complementary and Alternative Health Care:

☐ Nutrition/supplements
☐ Culturally traditional healing practices
☐ Energy/Polarity therapies
☐ Bodywork
☐ Traditional Oriental Practices
☐ Massage
☐ Other: _____

Your Information

Last Name: _____ First Name: _____

Home Mailing Address – Street (Street address preferred):

_____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Other Telephone Number: _____

Fax Number: _____ Email: _____

Date of Birth: _____ Is this complaint on your own behalf? ☐ Y ☐ N

*If no, fill out that person(s) information under Consumer/Client Information

Practitioner Information

Last Name: _____ First Name: _____

Mailing Address – Street (Street address preferred):

_____

City: _____ State: _____ Zip: _____

This address is: (check one) ☐ Home ☐ Business ☐ School ☐ Organization

Practitioner License (title and credential number if applicable): _____

Practitioner Web Address: _____

Email Address: _____

Practitioners Gender: ☐ Male ☐ Female ☐ Unknown ☐ Prefer not to disclose

Name of Practitioner's Organization or Business: _____

Address of Practitioner's Organization or Business: _____

_____

Consumer/Client Information

Last Name: _____ First Name: _____

Mailing Address – Street (Street address preferred):

_____

City: _____ State: _____ Zip: _____

This address is: (check one) ☐ Home ☐ Business ☐ School ☐ Organization

Telephone Number: _____ Other Telephone Number: _____

Fax Number: _____ Email: _____

Please check if you are: ☐ Practitioner's Supervisor ☐ Provider ☐ Other Licensed Practitioner
☐ Agency ☐ Employer ☐ Client/Consumer ☐ Relative/Friend ☐ Other: _____

Statement of Complaint

Provide a detailed description of the complaint with as much information as possible. If needed, you may attach additional pages. Please sign each additional statement of complaint page.

Signature: _____ Date: _____

Minnesota Department of Health
Health Occupations Program
PO Box 64882
St. Paul, MN 55164-0882
651-201-3731
Health.Hop@state.mn.us
www.health.state.mn.us

6/1/2017

To obtain this information in a different format, call 651-201-3731.