

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.

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COMPLAINT # \_\_\_\_\_ IN RE: \_\_\_\_\_

**SPECIFY CORRECTIVE ACTION YOU ARE SEEKING :**

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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.

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

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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