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:_____

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