



# Montana Department of LABOR & INDUSTRY

Business Standards Division

OPERATIONS BUREAU

301 S PARK AVENUE PO BOX 200514

HELENA MT 59620-0514

Phone: (406) 841-2333 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: \_\_\_\_\_ DOB: \_\_\_\_\_

**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. Text is limited to 970 characters so an additional sheet is acceptable. Please state "See attached document"

**LIST OF WITNESSES AND EVIDENCE:** Text is limited to 200 characters so an additional sheet is acceptable. Please state "See attached document"

**WHAT ACTION ARE YOU REQUESTING OF THE BOARD OR DEPARTMENT?**

**COMPLAINANT INFORMATION**

YOUR NAME \_\_\_\_\_

PHONE#: \_\_\_\_\_

YOUR MAILING ADDRESS \_\_\_\_\_

Street or PO Box

City/State

Zip Code

YOUR E-MAIL ADDRESS \_\_\_\_\_

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.*