BPL/IID-200 (01/17)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170
(517) 373-9196

Office Use Only
File #:

COMPLAINT FORM

Authority: Public Act 368 of 1978, as amended
Completion: Voluntary Penalty: None

Please be advised this agency DOES NOT assist citizens seeking reimbursement or resolution of billing or fee disputes or investigate anonymous complaints. In addition, this agency DOES NOT handle complaints against health care facilities.

INSTRUCTIONS: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the form to the address above. Please complete a separate form for each practitioner you are filing a complaint against.

Information About You			Complaint Being Filed Against	
Your Name			Practitioner's First and Last Name	
Street Address			Street Address	
City			City	
State	Zip Code	Country	State	Zip Code
Patient's Name			Practitioner's Telephone Number	
Patient's Date of Birth (MM/DD/YYYY)			Treatment/Incident Date	
Patient's Last 4 Digits of Their Social Security Number			Would you like to authorize a person other than yourself to communicate with the Department regarding your complaint? ☐Yes ☐No	
Your Telephone Numbers With Area Code Cell: Home: Work:			Name: Address: Telephone Number: Relationship to You:	

Check the profession for which you are lodging a complaint about:

- ☐Acupuncture
- ☐Allopathic Physician (MD)
- ☐Athletic Trainer
- ☐Audiologist
- ☐Chiropractor
- ☐Counselor
- ☐Dentistry
- ☐Marriage & Family Therapist
- ☐Massage Therapist
- ☐Nurse (RN or LPN)
- ☐Nursing Home Administrator
- ☐Physician's Assistant
- ☐Occupational Therapist
- ☐Optometrist
- ☐Osteopathic Physician (DO)
- ☐Pharmacist
- ☐Pharmacy Technician
- ☐Physical Therapist
- ☐Veterinarian
- ☐Podiatrist
- ☐Psychologist
- ☐Respiratory Therapist
- ☐Sanitarian
- ☐Social Worker
- ☐Speech/Language Pathologist

Are there civil actions pending?	Is there a police report?	May we release your name and this information to the practitioner?	Will you testify at an Administrative Hearing if necessary?
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.

Your Signature	**Date**

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.