

## Health Licensing Office – Consumer Complaint Form

**Note: Do not use this form for complaints against a Direct Entry Midwife – See Direct Entry Midwifery Complaint Form**

If you are using any Apple product (Mac, iPad, iPhone), download and use Adobe Reader before completing this form.

### SELECT REGULATED PROFESSION OR BUSINESS:

|                                                                                                          |                                                           |                                                         |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> ART THERAPISTS                                                                  | <input type="checkbox"/> DENTURE TECHNOLOGISTS            | <input type="checkbox"/> MUSIC THERAPISTS               |
| <input type="checkbox"/> ATHLETIC TRAINERS                                                               | <input type="checkbox"/> ELECTROLOGISTS                   | <input type="checkbox"/> POLYSOMNOGRAPHIC TECHNOLOGISTS |
| <input type="checkbox"/> BEHAVIOR ANALYSTS                                                               | <input type="checkbox"/> ENVIRONMENTAL HEALTH SPECIALISTS | <input type="checkbox"/> RESPIRATORY THERAPISTS         |
| <input type="checkbox"/> BODY ART (body piercers, tattoo artists)                                        | <input type="checkbox"/> HEARING AID DEALERS              | <input type="checkbox"/> SEXUAL OFFENSE THERAPISTS      |
| <input type="checkbox"/> CERTIFIED ADVANCED ESTHETICIANS                                                 | <input type="checkbox"/> LACTATION CONSULTANTS            | <input type="checkbox"/> SIGN LANGUAGE INTERPRETERS     |
| <input type="checkbox"/> COSMETOLOGISTS (barber, esthetician, hair design, nail tech, natural hair care) | <input type="checkbox"/> LICENSED DIETITIANS              | <input type="checkbox"/> TEMPORARY STAFFING AGENCY      |
|                                                                                                          | <input type="checkbox"/> LONG TERM CARE ADMINISTRATORS    | <input type="checkbox"/> WASTE WATER SPECIALISTS        |
| <input type="checkbox"/> DENTAL LABORATORIES                                                             |                                                           |                                                         |

### Complaint Against

|                                           |                              |                       |
|-------------------------------------------|------------------------------|-----------------------|
| BUSINESS NAME:                            |                              | DATE OF INCIDENT:     |
| NAME OF INDIVIDUAL:                       |                              | LICENSE # (if known): |
| STREET ADDRESS:                           |                              |                       |
| CITY:                                     | STATE:                       | ZIP:                  |
| ADDITIONAL LOCATION INFORMATION (if any): |                              |                       |
| CITY:                                     | STATE:                       | ZIP:                  |
| BUSINESS PHONE:                           | CELL PHONE (if applicable):  |                       |
| EMAIL:                                    | WEB ADDRESS (if applicable): |                       |

### Person Filing Complaint

|                                            |                              |                           |
|--------------------------------------------|------------------------------|---------------------------|
| NAME:                                      |                              | DATE OF FILING COMPLAINT: |
| STREET ADDRESS:                            |                              |                           |
| CITY:                                      | STATE:                       | ZIP:                      |
| MAILING ADDRESS (if different from above): |                              |                           |
| CITY:                                      | STATE:                       | ZIP:                      |
| BUSINESS PHONE:                            | CELL PHONE (if applicable):  |                           |
| EMAIL:                                     | WEB ADDRESS (if applicable): |                           |

### For Denture Complaints Only (if this is not a denture complaint, skip this section and move on to the next page)

Is this complaint specific to a denture or set of dentures? ☐ Yes ☐ No (if no, move on to the next page)

If your answer to the question above is yes, have the denture(s) been adjusted, worked on, or tampered with in any way since you initially received them? ☐ Yes ☐ No (if no, move on to the next page)

If your answer to the question above is yes, please provide the name and contact information of the person(s) who adjusted or worked on the denture(s):

**Describe the Nature of the Complaint / Affected Person(s) – Attach additional pages or your own documentation if necessary.**

**Complainant's Signature:**

**Date:**

The Health Licensing Office has no authority to require authorization holders or businesses to refund money to their clients. The office only has authority to investigate and take action when violation of Oregon Revised Statutes or Oregon Administrative Rules is proven.

### **Submission of this Form**

You may submit this form by email, fax or postal mail. This information can be found at the top of page one of this form.