STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 WWW.SPEECHANDHEARING.CA.GOV

CONSUMER COMPLAINT FORM

PLEASE PRINT OR TYPE

PERSON REGISTERING COMPLAINT		
NAME OF PATIENT		
NAME OF PERSON LODGING COMPLAINT **RELATIONSHIP TO PATIENT:**	**HOME TELEPHONE ( )** **WORK TELEPHONE ( )**	
ADDRESS (NUMBER AND STREET)		
CITY	**STATE**	**ZIP CODE**

PERSON COMPLAINT REGISTERED AGAINST		
NAME	**BUSINESS TELEPHONE** **( )**	
ADDRESS	**LICENSE NUMBER: (If known)**	
CITY	**STATE**	**ZIP CODE**

DETAILS OF COMPLAINT	
DATE OF VISIT _____/_____/_____ Month Day Year	**HOW LONG HAVE YOU BEEN A PATIENT?** _____ **Yrs.** _____ **Mos.**
	Attach additional page(s) if more space is needed.

CONSUMER COMPLAINT FORM (Cont.)

Attach additional pages if more space is needed.

I authorize the release of any information relating to my case from any speech-language pathologist, audiologist, or any health care practitioner who has provided treatment to me, including those persons listed above. I further agree that the Board and its representatives may release any and all of my records and treatment information to the Speech-Language Pathology, Audiology and Hearing Aid Dispensers Board and/or any other governmental agency which requests such information as part of an investigation into other possible violations of California laws and regulations.

The above information is a true and accurate statement regarding my complaint.

_____ _____

Signature Date

_____

Print Name