

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Professional Licensing Administration



717 14th Street, NW, Suite 600, Washington, DC 20005
(202) 724-4900 or (202) 724-8800
(202) 727-8471 Facsimile
website: www.hpla.doh.dc.gov

COMPLAINT FORM

PLEASE TYPE OR PRINT LEGIBLY IN BLACK OR BLUE INK.

The District of Columbia Health Professional Licensing Administration (“HPLA”) investigates complaints on behalf of the Health Occupations Boards (“Boards”). The Boards receive complaints and may take disciplinary action against a health professional licensee if the conduct in question is grounds for disciplinary action under the Health Occupations Revision Act of 1985 (D.C. Official Code § 3-1201.01 *et seq.*) or the District of Columbia Municipal Regulations. The disciplinary actions may include, but are not limited to, reprimand, probation, monetary fine, suspension or revocation of licensure. The Boards may also resolve the matter informally if there is no actual violation of a law or regulation or the Board otherwise deems such action appropriate.

THE BOARDS DO NOT HAVE JURISDICTION OVER THE FOLLOWING:

- **COMPLAINTS THAT INVOLVE FEE DISPUTES**
- **REQUESTS FOR REFUNDS**
- **A HEALTH PROFESSIONAL WHO IS NOT LICENSED IN THE DISTRICT OF COLUMBIA**

ACTIVITY THAT OCCURRED OUTSIDE OF THE DISTRICT OF COLUMBIA SHOULD BE REPORTED TO THE LICENSING BOARD OF THE STATE IN WHICH THE ACTIVITY OCCURRED.

If your complaint alleges unlicensed activity, you should address your complaint to:

Supervisory Investigator
Tenth Floor
717 14th Street, NW
Washington, DC 20005

You can also fax your complaint about unlicensed activity to (202) 727-8471.

Investigation and resolution of complaints take varying amounts of time. If a Board takes formal disciplinary action, you may obtain a copy of that Board’s final order from the Department of Health’s HPLA website at www.hpla.doh.dc.gov, and searching under that health professional’s name. If the Board closes your complaint with a finding that the health professional has not committed a violation of District of Columbia law or regulation, the Board will notify you of such in writing.

Complaints to a Board made on this form must be signed and dated by the individual making the complaint. Complaints are made available to the licensee so that he or she may file a response to the allegations with a Board. The Board will not accept an anonymous complaint. If you have any questions, please contact HPLA at (202) 724-4900 or (202) 724-8800.

1. IDENTIFY THE TYPE OF HEALTH PROVIDER

Place a check next to the appropriate provider.

- | | |
|--|---|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Addiction Counselor | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Anesthesia Assistant | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Dentist or Dental Hygienist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Dietician or Nutritionist | <input type="checkbox"/> Professional Counselor |
| <input type="checkbox"/> Marriage and Family Therapist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Naturopath |
| <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Other | |

2. IDENTIFY THE HEALTH PROVIDER

a. Full Name: _____
(Please Print)

b. Office/Facility Address: _____
(Street Address)

(City) (State) (Zip Code)

c. Office/Facility Telephone: _____

3. PERSON MAKING THIS COMPLAINT

a. Full Name: _____
(Please Print)

b. Home Address _____
(Street Address)

(City) (State) (Zip Code)

c. Home Telephone _____

d. Optional Telephone _____

4. PATIENT NAME (if different from person making this complaint)

a. Full Name: _____
(Please Print)

b. Home Address _____
(Street Address)

(City) (State) (Zip Code)

c. Patient's Date of Birth: ____ / ____ / ____

5a. Have you or the patient discussed your problem with the health professional who is the subject of this complaint? _____

5b. What was the outcome? _____

5c. Date(s) of occurrence(s) complained of: _____

5d. Place(s) of occurrence(s): _____

7. Please attach copies of any reports, bills, invoices, documents, or studies supporting or relating to your claim.

Copies of Supporting Documents Attached: _____ Yes _____ No

8. **I HEREBY DECLARE AND AFFIRM** under the penalties of perjury that the matters and facts set forth in the foregoing complaint are true and correct to the best of my knowledge, information and belief.

Date

Signature of Complainant

MAIL COMPLAINT TO:

DC Board of [*the Board that regulates the licensed professional about
whom you are complaining, e.g. Medicine, Dentistry, etc.*]
Suite 600
717 14th Street, NW
Washington, DC 20005

You can also fax the complaint to the appropriate Board at (202) 727-8471.