Government of the District of Columbia
Department of Health

Health Regulation and Licensing Administration
899 North Capitol Street, NE; 2nd Floor
Washington, DC 20002
(202) 724-4900 or (202) 724-8800
Facsimile: (202) 727-8471
Website: http://doh.dc.gov/

COMPLAINT FORM

PLEASE TYPE OR PRINT LEGIBLY IN BLACK OR BLUE INK.

The District of Columbia Health Regulation and Licensing Administration ("HRLA") 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
899 North Capitol Street, NE
Second Floor
Washington, DC 20002
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 HRLA website at http://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 HRLA at (202) 724-4900 or (202) 724-8800.

1. IDENTIFY THE TYPE OF HEALTH PROVIDER
Place a check next to the appropriate provider.

___ Acupuncturist
___ Addiction Counselor
___ Anesthesia Assistant
___ Audiologist
___ Chiropractor
___ Dentist or Dental Hygienist
___ Dietitian or Nutritionist
___ Marriage and Family Therapist
___ Massage Therapist
___ Nurse
___ Nursing Home Administrator
___ Occupational Therapist
___ Other
___ Optometrist
___ Pharmacist
___ Physician
___ Physician Assistant
___ Physical Therapist
___ Podiatrist
___ Professional Counselor
___ Psychologist
___ Respiratory Therapist
___ Naturopath
___ Social Worker
___ Speech Pathologist

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):

_____

_____

_____

6. Complaint

Please describe, with as much detail as possible, what event or events led to the filing of this complaint. Include in your description the dates and reason(s) for seeing the health provider. (You may choose to use a separate sheet of paper or the form below.)

PLEASE TYPE OR PRINT_____

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 AN D 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, etc.]

899 North Capitol Street, NE
Second Floor
Washington, DC 20002

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