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

899 North Capitol Street, NE; 2nd Floor; Washington, DC 20002
(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
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 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.

| | |
|---|---|
| _____ Acupuncturist | _____ Optometrist |
| _____Addiction Counselor | _____ Pharmacist |
| _____ Anesthesia Assistant | _____ Physician |
| _____Audiologist | _____ Physician Assistant |
| _____ Chiropractor | _____ Physical Therapist |
| _____ Dentist or Dental Hygienist | _____ Podiatrist |
| _____ Dietician or Nutritionist | _____ Professional Counselor |
| _____ Marriage and Family Therapist | _____ Psychologist |
| _____ Massage Therapist | _____ Respiratory Therapist |
| _____ Nurse | _____Naturopath |
| _____ Nursing Home Administrator | _____ Social Worker |
| _____ Occupational Therapist | _____ Speech Pathologist |
| _____ 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): _____

_____

_____

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 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.*]
899 North Capitol Street, NE
Second Floor
Washington, DC 20002

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