

MARYLAND BOARD OF OCCUPATIONAL THERAPY

SPRING GROVE HOSPITAL CENTER • TUERK BUILDING, 2ND FLOOR
 55 WADE AVENUE • BALTIMORE, MARYLAND 21228
 Phone 410-402-8560 • Fax 410-402-8561 • www.health.maryland.gov/botp

Board Use Only

Date Received _____
 Complaint No. _____

COMPLAINT FORM

Please type or print in black ink.

TO THE PERSON FILING THE COMPLAINT:

The Board investigates and acts upon complaints against occupational therapists/occupational therapy assistants if they involve violation of Maryland's Law concerning the occupational therapy profession (Title 10) of the Health Occupations Article. If your complaint is against someone other than an occupational therapist/occupational therapy assistant, the complaint should be directed to the Maryland Department of Health. However, if your complaint involves occupational therapy care given by someone who you think is not properly licensed, this information is certainly of interest to the Board and should be forwarded.

The Board will consider all complaints made upon this form if the person filing the complaint has signed and dated both this form and the affirmation that follows it. All spaces should be filled in as completely as possible. Whenever information is not known, please state that.

To speed up the processing of your complaint, please include the correct names, addresses, telephone numbers, both home and business for all persons named in the complaint, including your own, that of the occupational therapist/occupational therapy assistant, and all others. Whenever possible, please supply email addresses as well.

All complaints made to the Board are thoroughly considered and often referred for substantive investigation. If the Board decides to bring charges against an occupational therapist/occupational therapy assistant and holds a hearing thereon, advance notice must be given to the licensee to enable preparation of a defense. Therefore, in most cases, there is a considerable time lapse between the filing of the complaint and the hearing, if one is held. In all cases, you will be advised as to the outcome of your complaint. If after investigation, the Board decides to proceed with formal action, you may be called upon to testify as a witness.

If there is more than one person making this complaint, please use a separate form for each person.

1. Identify the Type of Health Provider - Place a check next to the appropriate provider.

- Occupational Therapist Occupational Therapy Assistant

2. Identify the Health Provider (the Respondent) – Please provide information for the licensee about whom you are complaining.

- a. Full Name: _____
- b. Business Address: _____
- c. Business Telephone Number: _____
- d. Email Address: _____

3. Contact Information for the Person Making This Complaint (the Complainant)

- a. Full Name: _____
- b. Home Address: _____
- c. Email Address: _____
- d. Home or Cell Phone Number: _____
- e. Business Address: _____
- f. Business Email: _____
- g. Business Telephone Number: _____
- h. Date of Birth: _____

4. Complaint Information

- a. Were you a patient of this therapist? Yes No
- b. If yes, indicate the time frame in which you were treated: _____
- c. Prior to filing this complaint, have you discussed your problem with the therapist identified above? Yes No
- d. If yes, what was the outcome? _____
- _____

- i. State the names, address, and contact information for any other individuals who have knowledge of your complaint and/or the occurrence(s).

Name	Address	Phone	Email
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- j. Have you registered this complaint with any other person or organization?

Yes No

If yes, to whom? _____

- k. For what condition were you being treated? _____

- l. Will you consent to the release to this Board or its designated investigating body, reports or records relating to you and to this occurrence from any hospital, related institution or therapist, including the therapist complained about? Yes No

If not, please provide an explanation. _____

IF THE COMPLAINT IS MADE BY A PERSON OTHER THAN THE PATIENT, ACTING IN AN OFFICIAL OR PROFESSIONAL CAPACITY, PLEASE FURNISH THE FOLLOWING ADDITIONAL INFORMATION. ALSO, PLEASE BE SURE TO READ, SIGN AND DATE THE LAST PAGE OF THIS COMPLAINT FORM.

5. Your official title or designation: _____

6. Did you personally investigate the matters set forth in this complaint? Yes No

a. If not, or if others assisted you in the investigation, state the names and titles of the person or persons, if any, who investigated or assisted in the investigation of such matters.

Name	Title	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Do you have any reports or other written communications directed to you with respect to the matters complained about? Yes No

a. If so, please attach copies of such reports and communications to this complaint.

8. Please provide any further information regarding this complaint which you wish to convey to the Board.

Date of complaint

Signature of complainant

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