



## MARYLAND STATE BOARD OF MASSAGE THERAPY EXAMINERS

4201 Patterson Avenue, Suite 301

Baltimore, MD 21215

410-764-5921 or 410-764-3677 (Complaint lines); [mdh.bcmte@maryland.gov](mailto:mdh.bcmte@maryland.gov) (Email)

**Please call if you are unsure to which Board you should direct your complaint.**

### INSTRUCTIONS FOR COMPLETING THE COMPLAINT PACKET

Please read the following instructions prior to completing the complaint form. Your complaint will be reviewed to verify that the complaint is a potential violation of Massage laws and/or regulations. Please type or print all information. Potential violations will be investigated and a summary of our findings will be sent to you, unless you choose to remain anonymous.

**FEE DISPUTES: If this complaint relates to fee disagreements between you and the massage service provider, note that the Board has no jurisdiction over those matters.**

#### COMPLAINT FORM

**PERSON FILING COMPLAINT:** Please type or print your name, email address, mailing address and phone numbers. The Complaint form is a fillable PDF or can be printed out and completed.

**INFORMATION ON ALLEGED VIOLATION:** Please type or print the name, address, name of business and phone numbers of the person or establishment whom you are filing the complaint against. If you are filing a complaint against more than one individual, please list the all names, addresses and phone numbers on a separate sheet.

**SUPPORTING DOCUMENTATION:** Supporting documentation is extremely important. Please enclose any documents that support your complaint. Documents **will not** be returned to you, so keep copies of your submission to the Board for your records.

**DETAILS OF COMPLAINT:** Below are suggestions that may help you in recalling details of your complaint. Date(s) of violation(s): List each date on which an alleged violation or incident occurred. Details of Complaint: Describe your complaint. Your narrative should address the reason(s) for your complaint. Please be as specific as possible by providing dates, places, times, etc. If specific information is not available, please give the next best available; i.e., "I cannot recall the exact date, but it was a Monday in January..." It is helpful if you can note how you are able to recall the date or day of the week. It is important to identify any individual(s) who may have knowledge of the event(s) that you have described. If possible, any such individual(s) should be fully identified by name, address and phone numbers. You may attach additional pages if necessary. Your complaint should include "who, what, when, where, how and possibly why."

**MAILING INSTRUCTIONS:** **Please keep a copy of your completed complaint form and any supporting documentation for your records.** Mail your completed packet to:

**Maryland State Board of Massage Therapy Examiners – Investigation Unit, 4201 Patterson Avenue, Suite 301, Baltimore, Maryland 21215.**

If you have questions, you may contact the Massage Therapy Board Investigator, at (410) 764-3677, (410) 764-5921, or by email at [bcmte@maryland.gov](mailto:bcmte@maryland.gov) .



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**COMPLAINT FORM**

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Please call if you are uncertain of which Board has jurisdiction over, and where to send your complaint.

<b>PERSON FILING COMPLAINT</b>	NAME (FIRST, MIDDLE, LAST)	CELL PHONE
	BUSINESS NAME (IF APPLICABLE)	WORK PHONE
	STREET ADDRESS	PERSONAL EMAIL ADDRESS
	CITY STATE ZIP	WORK EMAIL ADDRESS
	HAVE YOU REPORTED THIS MATTER TO ANOTHER AGENCY, THE POLICE OR AN ATTORNEY? IF YES, PLEASE LIST NAMES AND CONTACT INFORMATION.	
	HAVE YOU DISCUSSED YOUR COMPLAINT WITH THE FACILITY OWNER, PROGRAM DIRECTOR?	
<b>IDENTIFY THE SUBJECT OF THE COMPLAINT</b>	NAME OF MESSAGE THERAPIST OR PRACTITIONER WHO IS THE SUBJECT OF THIS COMPLAINT	CONTACT NUMBER IF KNOWN
	NAME OF FACILITY MGR., OWNER OR DIRECTOR (FIRST & LAST)	FACILITY PHONE
	FACILITY NAME	
	FACILITY STREET ADDRESS	
	CITY STATE ZIP	
	DATE(S) OF INCIDENT	
<b>WITNESSES (IF ANY)</b>	NAME (FIRST, MIDDLE, LAST)	CELL PHONE NUMBER
	STREET ADDRESS	WORK NUMBER
	CITY STATE ZIP	EMAIL ADDRESS
<b>WITNESSES</b>	NAME (FIRST, MIDDLE, LAST)	CELL PHONE NUMBER
	STREET ADDRESS	WORK NUMBER
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Use a separate sheet to list additional witnesses.

**NATURE OF COMPLAINT:** Please describe, in as much detail as possible, the exact nature of your complaint(s) against the massage therapist or massage practitioner including date(s), time(s) and location(s) of occurrence(s). Use as many additional sheets as necessary, number them and sign each one at the bottom. Submit any documentation available to support your complaint.

