MARYLAND STATE BOARD OF MASSAGE THERAPY EXAMINERS

4201 Patterson Avenue, Suite 301
Baltimore, MD 21215
410-764-5921 or 410-764-3677 (Complaint lines)

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 fee disputes.

COMPLAINT FORM

PERSON FILING COMPLAINT: Please type or print your name, 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. No documents will 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 also**. 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 or by email at **bcmte@maryland.gov .**

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COMPLAINT FORM

410-764-5921 or 410-764-3677 (Complaint line)
mdh.bcmte@maryland.gov (Email)

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PERSON FILING COMPLAINT	NAME (FIRST, MIDDLE, LAST)	HOME PHONE
	BUSINESS NAME (IF APPLICABLE)	WORK PHONE
	STREET ADDRESS	FAX NUMBER
	CITY STATE ZIP	OTHER (SPECIFY)
	HAVE YOU REPORTED THIS MATTER TO ANOTHER AGENCY? IF YES, PLEASE LIST NAME OF AGENCY:	
	HAVE YOU DISCUSSED YOUR COMPLAINT WITH THE FACILITY OWNER, PROGRAM DIRECTOR, ETC.?	
PLACE OF INCIDENT	NAME OF FACILITY MGR., OWNER OR DIRECTOR (FIRST & LAST)	FACILITY PHONE
	FACILITY NAME:	NAME OF MASSAGE THERAPIST OR PRACTITIONER
	FACILITY STREET ADDRESS	
	CITY STATE ZIP	
WITNESSES (IF ANY)	NAME (FIRST, MIDDLE, LAST)	HOME PHONE
	STREET ADDRESS	FAX NUMBER
	CITY STATE ZIP	OTHER (SPECIFY)
WITNESSES	NAME (FIRST, MIDDLE, LAST)	HOME PHONE
	STREET ADDRESS	FAX NUMBER
	CITY STATE ZIP	OTHER (SPECIFY)

Add sheets for additional witnesses, if needed.

Are you willing to testify if this matter proceeds to a formal hearing? _____ Yes _____ No

RELEASE OF RECORDS AUTHORIZATION

Do you consent to the release to this Board or its designated investigative body, any reports or records relating to you and to this occurrence from any massage business owner, healthcare provider or hospital, including the Massage Therapists/Practitioner complained of? Without records the Board will be limited in its investigation. _____ Yes _____ No

Signature _____ Date _____

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 (if applicable, against the facility or program) 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).

If you are filing this complaint on the behalf of someone else, please provide:

Name: _____ Contact Phone No.: _____

Address: City: _____ State: _____ Zip: _____

Affiliation to the Complainant: _____ Length of Time: _____

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

_____ _____

Signature Date