DEPARTMENT OF HEALTH & MENTAL HYGIENE

BOARD OF PROFESSIONAL COUNSELORS & THERAPISTS
4201 PATTERSON AVENUE
SUITE 316
BALTIMORE, MD 21215
(410) 764-4732
www.dhmh.maryland.gov/bopc

COMPLAINT FORM

PLEASE COMPLETE THIS FORM AND RETURN TO THE ABOVE ADDRESS

1. IDENTIFY THE TYPE OF HEALTH CARE PROVIDER

LCPC [☐]	**LCPAT [☐]**	**CAC-AD [☐]**
LGPC [☐]	**LGPAT [☐]**	**CSC-AD [☐]**
LCMFT [☐]	**LCADC [☐]**	**CPC [☐]**
LGMFT [☐]	**LGADC [☐]**	**TRAINEE [☐]**

2. IDENTIFY THE HEALTH CARE PROVIDER

Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
		Last	First	MI

Business Address:				
	Street	City	State	Zip Code

Office Telephone Number:	

3. CLIENT NAME

Name: Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
	Last	First	MI

Home Address:				
	Street	City	State	Zip Code

Date of Birth:	
Client's Telephone Number:	

4. IDENTIFY COMPLAINANT

If the person making the complaint is not the client, please provide the following information:

Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
		Last	First	MI

Home Address:				
	Street	City	State	Zip Code

Home Telephone Number:	
Office Telephone Number:	

5. IF YOU WERE THE CLIENT, LIST THE DATE(S) TREATED

6. RELATIONSHIP OF COMPLAINANT TO CLIENT

Client ☐	**Spouse** ☐	**Relative** ☐	**No Relation** ☐

7. WHAT, IF ANY ARE YOUR PROFESSIONAL OR PERSONAL RELATIONSHIPS WITH THE HEALTH PROVIDER?

8. STATE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE KNOWLEGDE OF YOUR COMPLAINT, INCLUDING ANY OTHER HEALTH PROVIDERS.

9. NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL

AS POSSIBLE, WHAT EVENT(S) LEAD TO THE FILING OF THIS COMPLAINT, INCLUDE THE DATES AND REASON FOR SEEING THE HEALTH CARE PROVIDER IN YOUR DESCRIPTION. **(PLEASE TYPE YOUR INFORMATION IN THE SPACE PROVIDED BELOW. ATTACH ADDITIONAL SHEETS IF NECESSARY)**

10. NATURE OF COMPLAINT: PLEASE DESCRIBE, WITH AS MUCH DETAIL

AS POSSIBLE, WHAT EVENT(S) LEAD TO THE FILING OF THIS COMPLAINT, INCLUDE THE DATES AND REASON FOR SEEING THE HEALTH CARE PROVIDER IN YOUR DESCRIPTION. **(PLEASE TYPE YOUR INFORMATION IN THE SPACE PROVIDED BELOW. ATTACH ADDITIONAL SHEETS IF NECESSARY)**

Insurance Identification Number:

Insurance Company Name:

Insurance Company Address:

11. LIST THE IDENTITY OF ANY PERSONS TO WHOM YOU HAVE MADE A SIMILAR COMPLAINT, INDICATE WHEN THE COMPLAINT WAS MADE.

12. WILL YOU CONSENT TO THE RELEASE TO THIS BOARD OR ITS DESIGNATED INVESTIGATING BODY, THE MEDICAL REPORTS RELATING TO YOU AND THIS OCCURRENCE FROM ANY CERTIFIED OR LICENSED COUNSELOR, HOSPITAL, RELATED INSTITUTION OR ANY MEDICAL DOCTOR?

Yes **[☐]** **No [☐]**

13. I HERE BY ATTEST THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEGDE AND BELIEFS, AND THAT I AM COMPETENT TO MAKE THESE STATEMENTS.

_____ _____

Date of Complaint Signature of Complainant

RELEASE OF MEDICAL AND CERTIFIED OR LICENSED PROFESSIONAL COUNSELORS RECORDS

I, _____
(Your name)

Of _____
(Your address)

Do hereby authorize _____
(Counselor's name)

to release to the Department of Health and Mental Hygiene of the State of Maryland, all records relating to your treatment of me during the period of _____ to the present, and permit discussion of the details of the treatment. This release is valid for one year.

_____ _____
(Date) (Signature)