MARYLAND
Department of Health

MARYLAND BOARD OF SOCIAL WORK EXAMINERS
4201 Patterson Avenue, *Phone Number:410-764-4788*
Baltimore. Maryland 21215 *Toll Free: 1-877-526-2541*
Website: http://www.health.maryland.gov/bswe *Fax: 410-358-2469*

Complaint Information Sheet

You have a right to expect a professional standard of care and conduct from a social worker. If you believe a social worker has violated Maryland statutes or regulations, you may send a written complaint to the Maryland Board of Social Work Examiners.
As the body responsible for regulating the social work profession and protecting the public in matters related to social work, the Board will review your complaint and take appropriate action. Complaints against hospitals or other health professionals should be filed with the State Department of Health.

Complaints that have been received in writing at the Board office will be acknowledged by letter, e-mail, or telephone. The complaint will then be reviewed by the Board's Disciplinary Complaint Review Committee at its next monthly meeting. If no violation appears to have occurred, the Committee will recommend that the Board dismiss the complaint and you will receive notification from the Board. If the Board believes a violation may have occurred, an investigation will take place. You will be contacted to provide additional details during the investigation. Once the investigation is complete, the full Board will review the complaint. At this time the Board may dismiss, request additional information, issue an informal sanction or file formal charges against the social worker. If the Board files formal charges against a social worker as a result of the investigation, an administrative hearing may be held. This formal hearing involves the complainant, lawyers, a court reporter, a hearing officer and witnesses. If the Board finds that the social worker has not met the prescribed standard of care and conduct, it has the authority to impose penalties ranging from a reprimand, suspension, or revocation of license. At any time after formal charges are filed, the Board may reach an agreement with the social worker regarding sanctions.

The Board's Disciplinary Complaint Review Committee meets the 2th Friday of every month. The full Board meets the 2nd Friday of the month. Depending on when the complaint is received and the complexities of the investigation, it generally takes three months to investigate a complaint. If formal action is taken and the complaint goes to a hearing, it could take considerably longer to resolve.

Filling a complaint

Complete the complaint form that accompanies this information sheet. Be sure to give all pertinent information names, dates, places. Please sign the complaint form and the “Authorization for Release of Information" form.

Complaint and Release forms and any supportive documentation should be mailed to:

Maryland Board of Social Work Examiners,
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COMPLAINT FORM

1) Complaint Filed Against:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip Code _____

Daytime Number _____ License # _____ E-Mail _____

Name of Employer _____

2) Person Filing Complaint: Please select applicable situation. if other is selected, please describe:

◉ Client ◯ Family/Friend ◯ Self Report ◯ Agency ◯ Insurer ◯ Licensed Professional ◯ Other

Describe _____

3) Name and address of person filing complaint

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip Code _____

Daytime Number _____ Cell Number _____ Fax Number _____

E-Mail _____

4) Does this complaint concern a child custody issue? (If no, go directly to question 7.)

◯ Yes ◯ No

5) Was the person named in this complaint appointed by the court to prepare a custody recommendation for the court?

◯ Yes ◯ No

6) Do you have joint LEGAL custody of the child/children involved in this case? Please provide documentation (i.e. , court orders, custody agreements, etc.)?

◯ Yes ◯ No

7) Have you tried to resolve or mediate this complaint with the health care provider directly?

If YES, what was the response:

_____

If not, why:

_____

8) Have you addressed your concern with your attorney or the court?
If yes, explain:

If no, why:

9) Statement: Please include the sequence of events surrounding your complaint, date of occurrence, name of witness and documents related to your complaint.

10) Name and address of first witness:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip Code _____

Daytime Number _____ Cell Number _____ Fax Number _____

E-Mail _____

11) Name and address of second witness:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip Code _____

Daytime Number _____ Cell Number _____ Fax Number _____

E-Mail _____

12) Name and address of third witness:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip Code _____

Daytime Number _____ Cell Number _____ Fax Number _____

E-Mail _____

13) Complainant is willing to give a sworn statement concerning the complaint?

◯ Yes ◯ No

14) Release of information completed and attached?

◯ Yes ◯ No

By signing this complaint , I assert that all information is true to the best of my knowledge.

_____ Date _____

Signature of Individual Making Complaint

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Authorization for Release of Information

1) Patient Name: _____

Date of Birth _____ Phone Number _____

2) I authorize _____ to release information to:

The State of MARYLAND BOARD OF SOCIAL WORK EXAMINERS

4201 PATTERSON AVENUE, BALTIMORE, MARYLAND 21215

3) Date(s) of service (Month, Day & Year to the best of your knowledge): _____

4) Specific information to be released:

☐ History & Physical Exam ☐ Psychiatric / Mental Health Evalutions ☐ Treatment Plan

☐ Progress Reports ☐ Discharge Plan ☐ Other (Specify): _____

5) Reason for disclosure: _____

6) I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.
This authorization (unless revoked) expires one year from the date provided below.

_____ Date _____
Signature (Patient/Legal Guardian/Parent)

_____ Date _____
Signature of Witness

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Your healthcare or payment for care will not be affected by weather you sign this authorization.

A photocopy or facsimile of this authorization will have the same authority as the original.

REVOCATION OF RELEASE OF INFORMATION

I hereby withdraw my consent for this release of information:

Signature _____ Date _____