



Governor Michael L. Parson
State of Missouri

Department of Insurance
Financial Institutions
and Professional Registration
Chlora Lindley-Myers, Director

DIVISION OF PROFESSIONAL REGISTRATION

CENTRAL INVESTIGATIONS UNIT
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
Telephone: 573-526-0162
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri
Email: central.investigations@pr.mo.gov
Web site: <http://www.pr.mo.gov>

Don Eggen
Chief Investigator

To: Complainant

From: Don Eggen
Chief Investigator

Re: Explanation of Complaint System

This is in response to your request for a complaint packet.

When filing a complaint, be sure to explain your allegations thoroughly in written form and provide copies of any documents, letters, bills, etc. that support your complaint.

In order for the licensee to release any information regarding services provided to you by a health care practitioner the individual receiving the services must sign the enclosed release of confidential information form(s). The release form(s) must be returned with the complaint. If the form(s) are not returned or incomplete your complaint may be delayed.

The licensee will receive a copy of the complaint and release form(s) and will be instructed to respond to the complaint you have filed within thirty (30) days.

Upon receiving a response from the licensee, your complaint will be reviewed by the Investigative Unit to make sure all the requested paperwork is included in the complaint file. If additional information is required, you will be contacted. The licensing agency will then review the entire complaint and response.

You will be notified in writing of the results of this review. Please understand details relating to the investigation, such as the licensee's response, or statements made relating to the investigation and review process are confidential.

Please send the uniform complaint form, release of confidential information form(s), and all pertinent documents to the attention of Don Eggen, Chief Investigator, Division of Professional Registration, Post Office Box 1335, Jefferson City, MO 65102.



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT

CENTRAL INVESTIGATION UNIT
 POST OFFICE BOX 1335
 JEFFERSON CITY, MO 65102
 TELEPHONE (573) 526-0162
 FAX (573) 751-5649
 TDD 800-735-2966

Section 575.060 — False Declarations. Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor. PLEASE TYPE OR PRINT IN BLACK INK

I WOULD LIKE TO FILE MY COMPLAINT WITH THE FOLLOWING BOARD:

- | | |
|---|--|
| <input type="checkbox"/> BEHAVIOR ANALYST ADVISORY BOARD | <input type="checkbox"/> COMMITTEE FOR SOCIAL WORKERS* |
| <input type="checkbox"/> BOARD FOR OCCUPATIONAL THERAPY* | <input type="checkbox"/> COMMITTEE OF DIETITIANS* |
| <input type="checkbox"/> BOARD FOR RESPIRATORY CARE* | <input type="checkbox"/> COMMITTEE OF INTERPRETERS* |
| <input type="checkbox"/> BOARD OF CHIROPRACTIC EXAMINERS* | <input type="checkbox"/> COMMITTEE OF MARITAL AND FAMILY THERAPISTS* |
| <input type="checkbox"/> BOARD OF EMBALMERS AND FUNERAL DIRECTORS | <input type="checkbox"/> COMMITTEE OF PSYCHOLOGISTS* |
| <input type="checkbox"/> BOARD OF EXAMINERS FOR HEARING INSTRUMENT SPECIALISTS* | <input type="checkbox"/> INTERIOR DESIGN COUNCIL |
| <input type="checkbox"/> BOARD OF GEOLOGISTS REGISTRATION | <input type="checkbox"/> OFFICE OF ATHLETICS |
| <input type="checkbox"/> BOARD OF PODIATRIC MEDICINE* | <input type="checkbox"/> OFFICE OF ENDOWED CARE CEMETERIES |
| <input type="checkbox"/> BOARD OF PRIVATE INVESTIGATOR EXAMINERS | <input type="checkbox"/> OFFICE OF TATTOOING, BODY PIERCING & BRANDING |
| <input type="checkbox"/> BOARD OF THERAPEUTIC MASSAGE* | <input type="checkbox"/> REAL ESTATE APPRAISERS COMMISSION |
| <input type="checkbox"/> COMMITTEE FOR PROFESSIONAL COUNSELORS* | <input type="checkbox"/> OTHER _____ |

*** YOU MUST COMPLETE THE ATTACHED RELEASE FORM FOR THE BOARD, COMMISSION OR COMMITTEE MARKED WITH AN ASTERISK (*). WITH THE RELEASE FORM SIGNED THE CENTRAL INVESTIGATIONS UNIT CAN OBTAIN YOUR MEDICAL OR THERAPEUTIC RECORDS.**

INFORMATION ABOUT YOU

YOUR NAME	TELEPHONE (DAYTIME)	CELL	TELEPHONE (EVENING)
ADDRESS (STREET, CITY, STATE, ZIP)			YOUR OCCUPATION
PREFERRED CONTACT	TELEPHONE	CELL	EMAIL

INFORMATION ABOUT LICENSEE OR PERSON PRACTICING WITHOUT A LICENSE

PERSON NAME AND/OR COMPANY	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)	PROFESSION
	LICENSE NO. (IF KNOWN)

	YES	NO		YES	NO
HAVE YOU CONTACTED LICENSEE OR UNLICENSED INDIVIDUAL ABOUT YOUR COMPLAINT? IF YES, DATE _____	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU CONTACTED AN ATTORNEY?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD A PROFESSIONAL OR SOCIAL RELATIONSHIP WITH THE PERSON YOU ARE FILING THE COMPLAINT AGAINST? IF SO, PLEASE EXPLAIN _____	<input type="checkbox"/>	<input type="checkbox"/>	HAS A LAWSUIT BEEN FILED?	<input type="checkbox"/>	<input type="checkbox"/>
			IT MAY BE NECESSARY FOR YOU TO TESTIFY AT A HEARING. ARE YOU WILLING TO TESTIFY?	<input type="checkbox"/>	<input type="checkbox"/>

ALL PERTINENT DOCUMENTS NEED TO BE ATTACHED

NAME OF YOUR PRIVATE ATTORNEY (IF APPLICABLE)	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)	

WITNESS: IF WITNESSES ARE LISTED, PLEASE PROVIDE CONTACT INFORMATION

NAME	ADDRESS AND TELEPHONE NUMBER

DETAILS OF COMPLAINT

GIVE FULL DETAILS OF YOUR COMPLAINT. Be specific. What happened? When? **USE BLACK INK.** Type or print legibly. Use additional sheets if necessary. Please attach all pertinent documents regarding this complaint.

Check here if you have included additional sheets or other materials.

NOTICE: All complaints must be signed. Such signature also authorizes the Board/Committee/Commission to release a copy of the complaint to the licensee who is the subject of the complaint.

SIGNATURE



DATE



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

STATE COMMITTEE OF INTERPRETERS

The purpose of this form is to allow the interpreter or anyone having knowledge about your complaint to talk about the complaint with an investigator, board member or state committee staff member.

I, _____, give my permission to release any records and discuss this complaint
 (YOUR NAME)

to _____
 (PERSON(S) THAT MAY TALK TO THE STATE COMMITTEE ABOUT YOUR COMPLAINT)

Information or records are to be released to the Division of Professional Registration/State Committee of Interpreters/Central Investigations Unit and/or its agents or representatives at the following address:

DIVISION OF PROFESSIONAL REGISTRATION
STATE COMMITTEE OF INTERPRETERS
P.O. BOX 1335
JEFFERSON CITY, MO 65102
(573) 526-7787

Please return copies of any records and this consent within 10 (ten) days.

I authorize any additional disclosure that may be necessary to accomplish the state's purpose in connection with any appearance before the professional regulatory agency and/or hearing before the Missouri Administrative Hearing Commission and/or any court of law.

Furthermore, I hereby waive and release the Division of Professional Registration, its member boards, commissions and committees, their respective members, and any employees, agents, or attorneys, including any former members, employees, agents, and attorneys of the Division of Professional Registration, its member boards, commissions and committees, the Commission for the Deaf of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including, but not limited to any claims for attorneys fees and expenses, including any claims pursuant to §536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this consent for the release of confidential information.

A photocopy of this signed release shall be treated like an original.

A copy of this consent form will be given to the person(s) you authorize to talk about the complaint.

SIGN YOUR NAME

PRINT YOUR NAME

DATE

NOTARIZED SIGNATURE REQUIRED IF NOT SIGNED IN PRESENCE OF A STATE INVESTIGATOR

STATE WITNESS SIGNATURE

PRINTED NAME

DATE

NOTARY PUBLIC EMBOSSE OR
 BLACK INK RUBBER STAMP SEAL

STATE

COUNTY (OR CITY OF ST. LOUIS)

SUBSCRIBED AND SWORN BEFORE ME, THIS

DAY OF

YEAR

USE RUBBER STAMP IN CLEAR AREA BELOW.

NOTARY PUBLIC SIGNATURE

MY COMMISSION
 EXPIRES

NOTARY PUBLIC NAME (TYPED OR PRINTED)