DEPARTMENT OF HEALTH

Complaint Form

HEALTH REGULATION DIVISION HEALTH OCCUPATIONS PROGRAM

Tennessen Warning

Minnesota Government Data Practices Act Notice: The Health Occupations Program in the Minnesota Department of Health (MDH) is asking for information (data) about your complaint. The data you provide is voluntary. MDH will use the data to investigate your complaint. According to the Government Data Practices Act, information gathered during the investigation is confidential. By completing and signing this document, you authorize MDH, its agents, and/or agents of the Attorney General's Office representing MDH to disclose the data to whom they reasonably believe need to know. MDH may use the data in legal proceedings.

After the investigation is closed, MDH classifies the investigative data as private data pursuant to Minnesota Statute 13.41. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

Consent Form

The Minnesota Department of Health asks that you complete the Minnesota Standard Consent Form to Release Health Information (https://www.health.state.mn.us/facilities/notices/docs/consent.pdf) and the complaint form provided below and send both completed forms via U.S. Mail or email to the address at the bottom of this document.

Complaint Information

What type of practitioner is this complaint about?

- ☐ Audiologist
- ☐ Occupational Therapist
- ☐ Body Art Technician or Establishment
- ☐ Hearing Instrument Dispenser
- ☐ Unlicensed Complementary and Alternative Health Care: _____
- ☐ Nutrition/supplements
- ☐ Culturally traditional healing practices
- ☐ Energy/Polarity therapies
- ☐ Occupational Therapy Assistant
- ☐ Speech Language Pathologist
- ☐ Bodywork
- ☐ Traditional Oriental Practices
- ☐ Massage
- ☐ Other: _____

Your Information

First and Last Name: _____

Home Mailing Address: _____

City: _____ State:_____Zip: _____

Telephone Number: _____

Other Telephone Number: _____ Fax: _____

Email: _____

Date of birth: _____

Is this complaint on your own behalf?

- ☐ Yes
- ☐ No (If no, fill out that person(s) information under Consumer/Client Information)

Practitioner Information

First and Last Name: _____

Home Mailing Address: _____

City: _____ State:_____Zip: _____

This address is (check one):

- ☐ Home
- ☐ Business
- ☐ School
- ☐ Organization

Practitioner License (title and credential number if applicable):_____

Practitioner Web Address:_____

Email:_____

Practitioner's Gender:

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Prefer not to disclose

Name of Practitioner's Organization or Business: _____

Address of Practitioner's Organization or Business: _____

_____

Consumer/Client Information

First and Last Name: _____

Home Mailing Address: _____

City: _____ State:_____ Zip: _____

This address is (check one):

- ☐ Home
- ☐ Business
- ☐ School
- ☐ Organization

Telephone Number: _____

Other Telephone Number: _____ Fax: _____

Email: _____

Please check if you are:

- ☐ Practitioner's Supervisor
- ☐ Provider
- ☐ Other Licensed Practitioner
- ☐ Agency
- ☐ Employer
- ☐ Client/Consumer
- ☐ Relative/Friend
- ☐ Other: _____

Statement of Complaint

Provide a detailed description of the complaint with as much information as possible. If needed, you may attach additional pages. Please sign each additional statement of complaint page.

Signature: _____ Date: _____

Minnesota Department of Health
Health Regulation Division
Health Occupations Program
PO Box 64882
St. Paul, MN 55164-0882
651-201-4200
health.Hop.MortSci.Complaints@state.mn.us
www.health.state.mn.us

04/26/2022

To obtain this information in a different format, call 651-201-4200.