Montana Department of
LABOR & INDUSTRY
Business Standards Division

OPERATIONS BUREAU
301 S PARK AVENUE PO BOX 200514
HELENA MT 59620-0514
Phone: (406) 841-2333 Fax: (406) 841-2363

FOR COMPLIANCE USE ONLY

Complaint # ____________________

Date Received: __________________

COMPLAINT AGAINST: ______________________________ LICENSE #: ____________________

PROFESSION / OCCUPATION TYPE: ____

BUSINESSES: ____

ADDRESS: ________________________ ____________ / ________ ____________
Street or PO Box City State Zip Code

If Applicable: PATIENT NAME: ______________________________ DOB: ________________

NATURE OF COMPLAINT: Please describe in detail the nature of the complaint, giving dates and other information. If service is part of the complaint, give information about telephone calls, contracts, etc. Text is limited to 970 characters so an additional sheet is acceptable. Please state “See attached document”

LIST OF WITNESSES AND EVIDENCE: Text is limited to 200 characters so an additional sheet is acceptable. Please state “See attached document”

WHAT ACTION ARE YOU REQUESTING OF THE BOARD OR DEPARTMENT?

COMPLAINANT INFORMATION

YOUR NAME ______________________________ **PHONE#**: ____________________

YOUR MAILING ADDRESS ________________________ ________________ ____________
Street or PO Box City/State Zip Code

YOUR E-MAIL ADDRESS ____

YOUR SIGNATURE: ______________________________ **DATE:** ________________

I hereby authorize that all of my protected health information maintained by any and all of my healthcare providers and that all of my health information maintained by any and all of my healthcare providers be furnished to the above-named licensing board and/or its agents. This authorization shall remain in effect until the licensing board has concluded all actions concerning this complaint.