South Carolina Department of Labor, Licensing and Regulation
Office of Investigations and Enforcement
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4470 • Fax: 803-896-4656

MEDICAL PROFESSIONS COMPLAINT FORM

- ☐ Chiropractic
- ☐ Counselors
- ☐ Dietetics
- ☐ Long Term Health Care
- ☐ Medical
- ☐ Nursing
- ☐ Occupational Therapy
- ☐ Opticianry
- ☐ Optometry
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Podiatry
- ☐ Psychology
- ☐ Social Work
- ☐ Speech Language Pathology & Audiology
- ☐ Veterinary

COMPLAINANT INFORMATION (Individual filing complaint)

Name: _____

Address: _____
Street/PO Box City State Zip Code

Contact Phone: _____ Email: _____

Alt. Phone: _____ Fax: _____

What is the best way to reach you? (Phone, email, etc.) _____

RESPONDENT INFORMATION (Individual the complaint is filed against)

Name: _____ License: _____
If applicable or known

Business Name: _____ Phone: _____

Address: _____
Street/PO Box City State Zip Code

WITNESSES
Provide name(s), address(es) and contact number(s). Attach additional sheet if more space is needed.

Name	Address	Phone

INCIDENT DETAILS

Alleged Violation: _____

Date(s) of Occurrence: _____

Please provide a statement of facts, allegations and/or, concerns. Attach a copy of each document you possess that can substantiate any facts in your complaint. These documents will not be returned. Please attach additional sheets, if necessary.

Have you attempted to contact the respondent concerning your complaint? YES ☐ NO ☐

If yes, when? _____

What was the result?

I attest that the information provided is true, correct and complete to the best of my knowledge.

_____ _____

Complainant Signature Date

☐ I have no objection of my name being released during the investigation.

☐ I do object to my name being released during the investigation.
* The department cannot guarantee that the name of the complainant can remain confidential throughout the investigation. Medical