DIVISION OF PROFESSIONAL LICENSURE
OFFICE OF INVESTIGATIONS
Application for Complaint

617-727-7406

www.mass.gov/dpl

Date Received (stamp):

Entered into the Database (Date): _____/ _____/ _____ **Docket #:_____-_____-_____**

Acknowledgement letter sent (Date): _____/ _____/ _____ **Signature: _____**

Please complete this form as fully as possible. **(PLEASE DO NOT WRITE ABOVE LINE.)** Please type or print legibly in ink.

SUBMITTED BY:

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code Evening Phone

Best way to reach you: ☐ Evening Phone ☐ Daytime Phone ☐ E-mail: _____

LICENSEE SEEKING COMPLAINT AGAINST (use separate form for each licensed individual/business):

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code License Number/Type Class

_____
Business Name

_____ _____
Business Address Daytime Phone

_____ _____ _____ _____
City State Zip Code Business License # / Type Class

Please check the trade or profession that this application for complaint pertains to

____	Accountant	_____	Funeral Director	_____	Optometrist
_____	Aesthetician	_____	Gas Fitter	_____	Physical Therapist
_____	Architect	_____	Hair Salon	_____	Physical Therapist Assistant
_____	Athletic Trainer	_____	Hair Stylist	_____	Plumber
_____	Audiologist/Speech Language Pathologist	_____	Health Officer	_____	Podiatrist
		_____	Hearing Aid/Instrument	_____	Psychologist
_____	Barber	_____	Home Inspector	_____	Radio/TV Tech.
_____	Barber Shop	_____	Land Surveyor	_____	Real Estate Agent/ Broker/Salesperson
_____	Chiropractor	_____	Landscape Architect	_____	Real Estate Appraiser
_____	Dietitian/Nutritionist	_____	Manicure Salon	_____	Rehab. Counselor
_____	Dispensing Optician	_____	Manicurist	_____	Sanitarian
_____	Drinking Water	_____	Marriage & Family Therapist	_____	Sheet Metal Workers
_____	Ed. Psychologist	_____	Massage Therapy	____	Social Worker
_____	Electrician	_____	Mental Health Counselor	_____	Veterinarian
_____	Electrologist	_____	Occupational Therapist		
_____	Engineer	_____	Occupational Therapist Assist		
_____	Fire or Burglar Alarm				

Description of the incident(s):

Briefly describe the incident(s) that led to your application for complaint and note the times and dates that events occurred. List the names of all individuals involved. Please attach additional pages if needed.

(Please use a separate sheet if necessary. Do not write in the margins.)

Additional information or materials attached ☐ Yes ☐ No

To speed up the application for complaint process, submit legible copies (not the originals) of all relative documents supporting your application (e.g. contracts, medical records, cancelled checks, etc.). You will receive an acknowledgement letter notifying you if a complaint is issued based on your application. If a complaint is not issued, you will receive information on additional resources that may be available to you.

AUTHORIZATION FOR RELEASE OF RECORDS AND FORM REFERRAL

My signature to this form, or a photocopy thereof, authorizes the Division of Professional Licensure to:
(1) receive copies of all medical, dental and mental health records relating to my application for complaint, and (2) to refer my application for complaint to other appropriate law enforcement authorities to investigate and/or prosecute.

Please note that all applications for complaints are examined to determine their factual basis. The act of filing an application for complaint does not assure or imply that disciplinary action will be taken against the licensee.

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

Signature Date

Mail this form to:
Division of Professional Licensure, Office of Investigations
1000 Washington Street, Suite 710
Boston, MA 02118