



DEPARTMENT OF PUBLIC HEALTH
DRUG CONTROL PROGRAM

www.mass.gov/dph/dcp

COMPLAINT FORM

Date Received (stamp):

Please complete this form as fully as possible. Please type or print legibly in ink.

COMPLAINT 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: _____

COMPLAINT AGAINST (use separate form for each business or individual):

Name: _____
Last Name First Name M.I.

Address: _____
Number Street Daytime Phone

City State Zip Code Profession

Business Name

Business Address Daytime Phone

City State Zip Code Business Type

Description of the Complaint:

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

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

Complainant signature

Date

Mail this form to: Department of Public Health, Drug Control Program, 99 Chauncy Street, Boston, MA 02111

Of fax form to: (617) 753-8083

Tel. (617) 983-6700