



**DIVISION OF OCCUPATIONAL 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                              | _____ Fire / Burglar Alarm Installer    | _____ Occupational School Sales            |
| _____ Aesthetician                            | _____ Funeral Director                  | _____ Representative                       |
| _____ Architect                               | _____ Gas Fitter                        | _____ Occupational Therapist               |
| _____ Athletic Trainer                        | _____ Hair Salon                        | _____ Optometrist                          |
| _____ Audiologist/Speech Language Pathologist | _____ Hair Stylist                      | _____ Physical Therapist                   |
| _____ Barber                                  | _____ Health Officer                    | _____ Plumber                              |
| _____ Barber Shop                             | _____ Hearing Aid/Instrument Specialist | _____ Podiatrist                           |
| _____ Barber Schools                          | _____ Home Inspector                    | _____ Psychologist                         |
| _____ Chiropractor                            | _____ Land Surveyor                     | _____ Real Estate Agent/Broker/Salesperson |
| _____ Cosmetology School                      | _____ Landscape Architect               | _____ Real Estate Appraiser                |
| _____ Dietitian/Nutritionist                  | _____ Manicure Salon                    | _____ Rehab Counselor                      |
| _____ Dispensing Optician                     | _____ Manicurist                        | _____ Sanitarian                           |
| _____ Drinking Water Operator                 | _____ Marriage & Family Therapist       | _____ Sheet Metal Worker                   |
| _____ Electrician                             | _____ Massage Therapist                 | _____ Social Worker                        |
| _____ Electrologist                           | _____ Mental Health Counselor           | _____ Veterinarian                         |
| _____ Engineer                                | _____ Occupational School               |  |

**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.

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(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 Occupational Licensure, Office of Investigations  
1 Federal Street, Suite 0600  
Boston, MA 02110