



The Commonwealth of Massachusetts  
**Office of Local and Regional Health**  
 RS/CHO Credentialing  
 91 East Mountain Road, Clark Building  
 Westfield, MA 01085

**Complaint Form**

Date Received: \_\_\_\_\_

Date Entered into Database: \_\_\_\_\_ Complaint #: \_\_\_\_\_

Acknowledgement Letter sent: \_\_\_\_\_ OLRH Employee Initials: \_\_\_\_\_

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

**SUBMITTED BY:**

Name:

\_\_\_\_\_

*Last Name* *First Name* *M.I.*

Address:

\_\_\_\_\_

*Number* *Street* *City* *State* *Zip Code*

Contact:

\_\_\_\_\_

*Email Address* *Telephone Number*

**CREDENTIALLED INDIVIDUAL THE COMPLAINT IS AGAINST**

(Use a separate form for each individual/business)

Name:

\_\_\_\_\_

*Last Name* *First Name* *M.I.*

Address:

\_\_\_\_\_

*Number* *Street* *City* *State* *Zip Code*

Contact:

\_\_\_\_\_

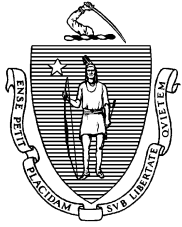
*Telephone Number* *Credential # (if known)*

Business:

\_\_\_\_\_

*Business Name*

APPLICATION CONTINUED ON PAGE 2



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Business Address:

\_\_\_\_\_  
*Number Street City State Zip Code*

Business Contact:

\_\_\_\_\_  
*Telephone Number Business License# (if known)*

**Please check the profession that this application for complaint pertains to:**

**Sanitarian**

**Health Officer**

**Description of the Incident(s):**

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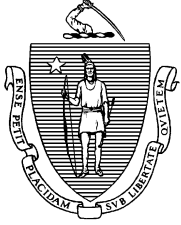
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*(Please use separate sheet if necessary. Do not write in the margins.)*

To expedite the application for complaint process, submit legible copies (not originals) of all relative documents supporting your application (e.g., contracts, emails, 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 an explanation, and information on additional resources that may be available to you if such exist.

Additional information or materials attached      Yes      No

APPLICATION CONTINUED ON PAGE 3



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### ATTESTATION AND AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL FORM

My signature on this form, or photocopy thereof, authorizes the Department of Public Health to: (1) receive copies of all my health records relating to my complaint; (2) to share the complaint and all records collected by the Department of Public Health during the investigation of my complaint with the credentialed individual for the credentialed individual's use in responding to the allegations in this complaint; and (3) to refer my complaint to other regulatory and/or law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis.

**The act of filing a complaint and its receipt and/or investigation by the Department of Public Health does not mean that disciplinary action will be taken against the credentialed individual.**

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information, and belief.

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

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*Signature*

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*Date*

Completed forms should be emailed to [RS.CHO@mass.gov](mailto:RS.CHO@mass.gov)

Alternatively, forms can be mailed to:  
The Office of Local and Regional Health  
RS/CHO Credentialing  
91 East Mountain Road  
Westfield, MA 01085