

DIVISION OF PROFESSIONAL LICENSURE

OFFICE OF INVESTIGATIONS

Application for Complaint

617-727-7406 www.mass.gov/dpl

Date Recei Entered into	ved: o the Database (Date):	′/	Docket #:		
Acknowledg	gement letter sent (Date):				
Please comp	lete this form as fully as possibl				y in ink.
SUBMITTE	ED BY:				
Name:	Last Name		First Name	M.I.	
Address:	Number Street		Phone		
	City E-mail:		State Zip Code	Alternate Phone	
LICENSEE Name:	THE COMPLAINT IS AGAI	INST (use separat	e form for each lic	ensed individual/business):	
	Last Name		First Name	M.I.	
Address:	Address: Number Street		Phone		
	City		State Zip Code License Number (if known		wn)
	Business Name				
	Business Address City			Phone	
			E Zip Code Business License # (if applicable/known)		ble/known)
Please chec	ck the trade or profession th	nat this applicati	on for complain	t pertains to:	
Accountant Aesthetician Aesthetic Shop Applied Behavior Analyst Architect Athletic Trainer Audiologist/Speech Language Pathologist		Remov — Engineer — Fire/Burgl — Funeral D — Gas Fitter	y / Laser Hair al ar Alarm Installer irector / Home	Massage EsMassage ThMental HeaOccupationsOccupations	Ith Counselor al School al School Sales
Barber Shop Barber School Chiropractor Cosmetology School Dietitian/Nutritionist Dispensing Optician		Hair Salor Hair Stylis Health Off Hearing Ir Home Insp Land Surv Landscape	st ficer astrument Specialist pector eyor	Optometrist	al Therapist erapist
_	Drinking Water Operator —		Salon		

Real Estate Agent/Broker/SalespersonReal Estate Appraiser	Sanitarian Sheet Metal Worker Social Worker
Rehab Counselor	Veterinarian
Description of the incident(s):	
	that led to your application for complaint and note the times and dates that sof all individuals involved. Please attach additional pages if needed.
(Please use a sep	parate sheet if necessary. Do not write in the margins.)
Additional informatio	on or materials attached Yes No
supporting your application (e.g. contract acknowledgement letter notifying you if a	at process, submit legible copies (not the originals) of all relative documents ts, medical records, cancelled checks, etc.). You will receive an a complaint is issued based on your application. If a complaint is not issued, ormation on additional resources that may be available to you if such exist.
AUTHORIZATION FOR RE	LEASE OF RECORDS AND FORM REFERRAL
(1) receive copies of all medical, dental a	y thereof, authorizes the Division of Professional Licensure to: and mental health records relating to my application for complaint, and (2) to her appropriate law enforcement authorities to investigate and/or prosecute.
	mplaints are examined to determine their factual basis. The act of filing a ure or imply that disciplinary action will be taken against the licensee.
I attest that the information provided is tr	rue, 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