OHIO RESPIRATORY CARE BOARD
COMPLAINT FORM

_____

Docket Number

Office Use Only

NAME OF COMPLAINANT _____ DATE _____

(Your Name)

ADDRESS OF COMPLAINANT _____

_____

_____

TELEPHONE Home: ( ) _____ Work: ( ) _____

COMPLAINT AGAINST: _____

(Name)

Address: _____

_____

Telephone: Home: ( ) _____ Work: ( ) _____

Nature of Complaint:_____

_____

_____

_____

_____

Date(s) of alleged offense(s) _____

Location of alleged offense(s) _____

What would you like the Ohio Respiratory Care Board to do about your complaint?

_____

_____

_____

If the Ohio Respiratory Care Board should find grounds for an Administrative Hearing, it may be necessary for you to appear as a witness under subpoena. Would you be willing to testify? [ ] yes [ ] no

Please return completed and signed complaint form to:

Ohio Respiratory Care Board
77 South High Street, 16th Floor
Columbus, Ohio 43215-6108

_____

Signature of Complainant

(Person making the complaint)

*You may attach separate sheets for any additional comments you wish to make.