STATEMENT OF COMPLAINT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

Please note that investigations by this office are confidential and privileged (See 63 Pa.C.S. § 3109). If this matter is closed without the initiation of formal disciplinary action, this office is prohibited from providing you with any additional information regarding the specific concerns which caused the file to be opened, the evidence gathered during our review and investigation, or the specific reasoning that led to this office's decision. Be sure to keep copies of all documents forwarded to the Commonwealth as confidentiality statutes may prevent us from returning these items to you. Additionally, access to this information may be restricted while the file is under investigation. By submitting this complaint, you acknowledge that you understand that statements in this complaint are made subject to the criminal penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities. Please return this completed form to: **DEPARTMENT OF STATE, PROFESSIONAL COMPLIANCE OFFICE, P.O. BOX 69522, HARRISBURG, PA 17106- 9522.**

TYPE OF COMPLAINT: ☐ PROFESSIONAL/OCCUPATIONAL LICENSE/CERTIFICATE/REGISTRATION ☐ NOTARY ☐ OTHER

A. COMPLAINANT INFORMATION

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code) (HOME)	(WORK)		

B. COMPLAINANT'S ATTORNEY, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code)	FIRM NAME		

C. NAME AND ADDRESS OF WITNESS, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code)	If needed, is this witness willing to appear at a hearing? ☐ YES ☐ NO		

D. NAME AND ADDRESS OF SECOND WITNESS, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code)	If needed, is this witness willing to appear at a hearing? ☐ YES ☐ No		

NOTE: If additional witnesses are available, list names, addresses, and other pertinent data in a manner similar to above on 8½ x 11" paper.

E. ARE YOU WILLING TO APPEAR AT A HEARING IN HARRISBURG IF NECESSARY? ☐ YES ☐ NO

RESPONDENT/LICENSEE INFORMATION

F. BUSINESS ESTABLISHMENT INVOLVED, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code)	PROPRIETOR		

G. INDIVIDUAL INVOLVED, IF ANY

LAST NAME	FIRST	MIDDLE INITIAL	
STREET ADDRESS (Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
TEL. (Include Area Code)	LICENSE/REGISTRATION/ CERTIFICATE/COMMISSION TYPE AND NUMBER IF KNOWN		

H. THIS SECTION IS FOR NOTARY COMPLAINTS ONLY:

Expiration date of notary's commission if known *(this date should appear on the notary's stamp, printed beneath the notary seal)*:	Date of transaction for which this complaint is being filed:
_____	_____

I. DESCRIPTION OF COMPLAINT

Please describe your complaint in detail below. State the facts briefly and clearly. List services provided by the licensee, registrant, certificate holder or commission holder. Provide relevant dates. List fees paid for notary services, if applicable. Attach **copies** of related documents that support your complaint. Do **NOT** enclose original documents, as they cannot be returned to you. If you need more space to describe your complaint, please continue on additional 8½ x 11" sheet(s) of paper.

Complaints should be typewritten or clearly printed in black or blue ink.
Please keep a copy of your Statement of Complaint form for your records.

J. RESOLUTION

How would you like this complaint to be resolved?

_____

_____

_____

_____

_____

_____

_____

K. COMPLAINANT'S VERIFICATION

I verify that the facts and statements set forth in this complaint are true and correct to the best of my knowledge, information and belief. I understand that statements in this complaint are made subject to the criminal penalties of 18 Pa.C.S. §4904 relating to unsworn falsification to authorities.

x _____
(FIRST COMPLAINANT'S SIGNATURE)

DATE: _____

x _____
(SECOND COMPLAINANT'S SIGNATURE, IF ANY)

DATE: _____

x _____
(SIGNATURE OF PERSON COMPLETING THIS FORM, IF OTHER THAN COMPLAINANT)

DATE: _____

SUBMIT COMPLETED FORM BY MAIL TO: **Professional Compliance Office**
Department of State
P.O. Box 69522
Harrisburg, PA 17106-9522
OR BY: **Fax 717-705-2882**

L. RECORDS RELEASE *(PLEASE COMPLETE IF IT APPLIES TO YOUR COMPLAINT).*

TO WHOM IT MAY CONCERN:

THIS WILL AUTHORIZE _____
(Name of physician, practitioner, hospital or clinic)
to release to the Department of State and its authorized representatives any pertinent medical records and copies of x-rays relating to

_____
(Patient's name)
for the purpose of investigating a complaint.

_____
Signature

Date:

_____
Witness

Date:

THANK YOU FOR BRINGING YOUR CONCERNS TO OUR ATTENTION.