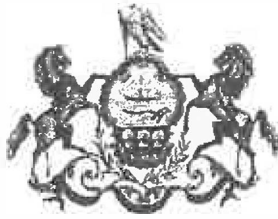


STATEMENT OF COMPLAINT



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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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			

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.

(FIRST COMPLAINANT'S SIGNATURE)

(SECOND COMPLAINANT'S SIGNATURE, IF ANY)

DATE: _____

DATE: _____

(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

Witness

Date:

Date: