

Allegation ID # _____

Speech Language Pathologists

COMPLAINT FORM

To assist you with your complaint, the Minnesota Department of Health asks that you complete this form and submit it, with your written statement, via U.S. Mail to:

Minnesota Department of Health
Health Occupations Program
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Based on the information you provide, an investigation will be conducted. Please type or print clearly, using black ink.

Information about the person making the complaint:

Your Name _____
 First Middle Last

Check one: Mr. Mrs. Ms. Dr.

Address: _____
 Street Name State Zip County

This address is: (check one) home business school organization

Telephone Numbers: Home _____

 Business _____

 Cell _____

 Fax _____

Your Birth Date _____ / _____ / _____
 Month Day Year

Is this complaint on your own behalf? Yes / No (circle one)

If you answered No to the above question, please provide the following information concerning the consumer for whom you are filing this complaint:

Practitioner's Telephone Numbers: Home _____

Business _____

Cell _____

Fax _____

Practitioner Gender: Male Female

Practitioner's Name of Organization or Business: _____

Address of Practitioner's Organization or Business: _____

Narrative description of your complaint: on the attached sheets, please describe what occurred, where and when the incident transpired and who was involved. Include in your narrative your relationship to the practitioner, where the practitioner was employed at the time of the incident, and any previous or subsequent encounters you may have had with the practitioner. If possible, please include the identities and phone numbers of anyone who may have either witnessed the incident or have additional information regarding either the incident or the practitioner. Please include copies of any supporting documents you may have. You may use additional sheets if necessary. **Your rights are described under the Tennessee Warning included in this packet.**

What would you like to see happen to resolve this complaint? _____

Speech Language Pathologist Practice Information

1. Was the service provided by a Speech-Language Pathologist or a Speech Language Pathologist Assistant?

_____ Speech Language Pathologist

_____ Speech Language Pathologist Assistant

2. If the service was provided by a Speech-Language Pathologist Assistant, provide the Assistant's Supervisors name, title, address and telephone number

3. Which of the following describes the service site?

_____ Hospital

_____ Skilled Nursing Facility

_____ Rehab Facility

_____ Clinic/Private Practice

_____ School

_____ Home Health Care

_____ Other (describe) _____

4. Which of the following best describes the type of service received? (Circle all that apply)

_____ Treatment

Speech-Language cognitive, swallowing voice

_____ Evaluation only

Speech-Language cognitive swallowing voice

5. Did your health insurance or other type of third party payer pay for these services
_____ No _____ Yes If yes, what type of payer paid for the services? _____

6. What was the duration of therapy?

_____ Less than 3 months

_____ Between 3 and 6 months

_____ Between 6 months and 1 year

_____ More than one year

NARRATIVE DESCRIPTION OF COMPLAINT

Please use these sheets to describe your complaint, using the directions explained on the complaint form. Be sure to include dates, places and full names of person(s) involved, if known. You may use additional sheets, if necessary. However, if you do use additional sheets, **please sign and date each additional sheet.**

Signature: _____ Date: _____

TENNESSEN WARNING

Under the Minnesota Government Data Practices Act, information given to the Minnesota Department of Health (MDH) as part of an active investigation of a complaint against a practitioner is confidential. Such information is for the use of the MDH in the evaluation of the complaint, and if necessary, bringing legal action against the practitioner. In some circumstances, investigative information received from you about a practitioner may be disclosed to certain other persons or entities, including the Attorney General’s Office, the Office of Administrative Hearings, members of the advisory council, any subsequent reviewing court and any other government agency deemed necessary by the MDH.

As a consumer, you are not required to cooperate with the MDH, but not cooperating could hamper our ability to investigate the matter. Practitioners regulated by MDH are required by statute to cooperate with an investigation by the MDH. A practitioner refusing to cooperate may result in the MDH taking disciplinary action against the practitioner.

After an investigation is closed, the investigative data is classified as private data pursuant to Minnesota Statute 13.41. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

Client Records Waiver Authorization

(Please complete, sign and date)

TO: _____ (Client’s physician, clinic, or applicable provider)

Having been informed of my rights under the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13, I authorize the physician, clinic, or applicable provider named above to furnish a copy of my records in their possession, to allow those records to be inspected and/or copied by the MDH, and any other appropriate state or federal government agencies. I further authorize the physician, clinic, or applicable provider named above to testify without limitation as to any and all of their findings and/or treatment referred to in said records. I release the MDH, its agent(s), and the agent(s) of the Attorney General’s Office representing the MDH from liability for so releasing said records or said testifying, and I waive my privileges afforded me by the law relating to the disclosure of introduction into evidence of health information.

This consent is subject to express revocation at any time except to the extent that action has been taken in reliance on this consent. Unless express revocation is made, this consent is revoked upon conclusion of the MDH’s investigation. A photocopy of this release shall be as valid as the original. I also agree to permit and hereby authorize the MDH to use my name and/or records in any legal proceeding arising out of this matter.

NAME: (please print) _____ DATE: _____

SIGNATURE authorizing release of information: _____

If not signed by the client involved in the matter, what is your relationship to the client?
