

# **Mortuary Science**

COMPLAINT FORM

## **Tennessen Warning**

MINNESOTA GOVERNMENT DATA PRACTICES ACT NOTICE: The Mortuary Science Section in the Minnesota department of Health (MDH) is asking for information (data) about your complaint. The data you provide is voluntary. MDH will use the data to investigate your complaint. According to the Government Data Practices Act, information gathered during the investigation is confidential. By completing and signing this document, you authorize MDH, its agents, or agents of the Attorney General's office representing MDH to disclose the data to whom they reasonably believe need to know. MDH may use the data in legal proceedings. After the investigation is closed, MDH classifies the investigative data as private data pursuant to <u>Minnesota Statute 13.41</u>. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

To file a complaint with the Mortuary Science Section, please fill out the information on this form and return to the address below.

Minnesota Department of Health Mortuary Science Section P.O. Box 64882 St. Paul, Minnesota 55164-0882

On the attached pages, describe in detail the reason for your complaint. You may use additional pages if necessary.

## **Your Information**

Last Name	First Name	Middle	
Mailing Address	City	State	Zip
Phone Number	Email		
Name of Name/Esta	ablishment You are Rep	oorting	
Type of Complaint			
		Other	
Funeral Home	Licensee	Other	
<ul><li>Funeral Home</li><li>Crematory</li></ul>	<ul><li>Licensee</li><li>Intern</li></ul>		
Crematory	□ Intern		

#### Notice

The information you provide may be used in efforts to resolve your problem with the subject of this complaint or to enforce applicable laws. This information, except for the identity of the complainant, may be shared with the subject of the complaint, law enforcement agencies, and the attorney general's office or other government agencies that may need to know. You are not required by law to provide this information. I understand that providing the information may assist in the proper and thorough investigation of the complaint.

Please be as complete as possible in your description of the reason for your complaint. Include copies of information you may have received from the subject of the complaint if you feel they may be helpful.

### Acknowledgement to Notice

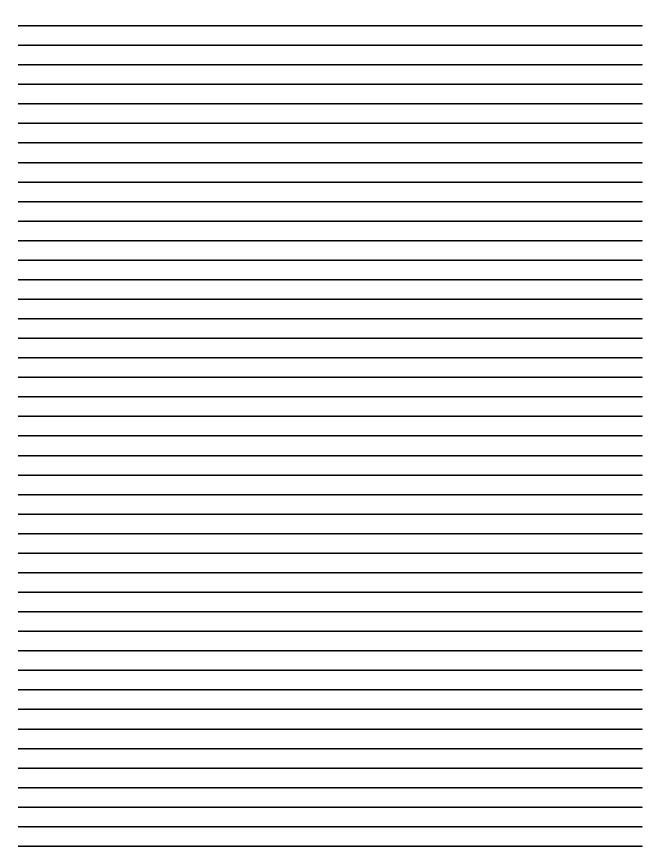
The information I have provide is true and accurate to the best of my knowledge and may be used as stated above.

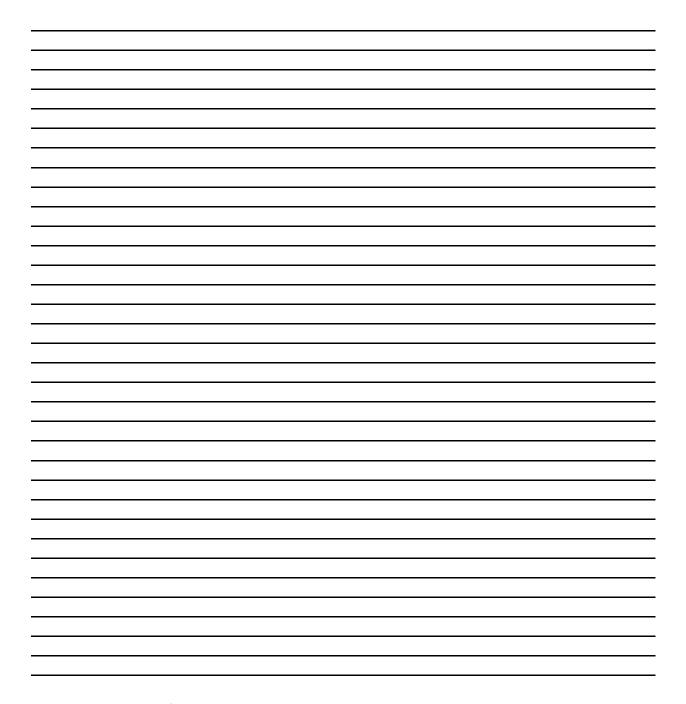
Signature of Complainant

Date

## **Statement of Complaint**

Provide a detailed description of the complaint with as much information as possible. If needed, you may attach additional pages. Please sign each additional statement of complaint page.





Minnesota Department of Health PO Box 64882 St. Paul, MN 55164-0882 651-201-3829 health.mortsci@state.mn.us www.health.state.mn.us

11/30/2020

To obtain this information in a different format, call: 651-201-3829. Printed on recycled paper.