West Virginia Board of Examiners for Speech-Language Pathology & Audiology
99 Edmiston Way
Box 11, Suite 214
Buckhannon, WV 26201
Phone: 304-473-4289 Fax: 304-473-4291
wvbeslpa@wv.gov
www.wvspeechandaudiology.com

Consumer Complaint

Carefully read all of the questions before you begin. Provide as much detail as possible and respond to each question. Use additional blank sheets of paper, if required. If a question is not applicable to your complaint, note with N/A.

Complaint being filed by:

Full Name: ______________________________

Home Address: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Complaint being filed against:

Full Name: ______________________________

Name of Facility: ______________________________

Facility Address: ______________________________

Facility Phone: ______________________________

Nature of Complaint:

1—Were you a patient of this professional? ____________

If yes, list date(s) of treatment. If No, state your reason for involvement in this complaint and proceed to Question 3.

2—For what condition(s) were you treated?

Board of Examiners for Speech-Language Pathology and Audiology
WEST VIRGINIA
1992
SEAL

3—Have you discussed your complaint with the professional? _________________

If Yes, what were the results? If No, why not?

4—If you were a patient, include billing records or other documentation in your possession that will assist the Board in its investigation of your complaint.

5—Have you filed this complaint with any other person or organization? __________

If Yes, with whom?

Name: ____________________

Address: ____________________

Phone: ____________________

Board of Examiners for Speech-Language Pathology and Audiology
WEST VIRGINIA
1992
SEAL

Witness Information:

List individuals who are witnesses to the incident(s):

Name: ____________________

Address: ____________________

Phone: ____________________

Name: ____________________

Address: ____________________

Phone: ____________________

List individuals who have knowledge of the incident(s):

Name: ____________________

Address: ____________________

Phone: ____________________

Name: ____________________

Address: ____________________

Phone: ____________________

I hereby declare and affirm that the information given above regarding my complaint is, to the best of my knowledge, accurate and true.

____

Signature ` Date

West Virginia Board of Examiners for Speech-Language Pathology & Audiology
99 Edmiston Way
Box 11, Suite 214
Buckhannon, WV 26201
304-473-4289
wvbeslpa@wv.gov
www.wvspeechandaudiology.com

Consent for Release of Information

I, the undersigned, do consent to the release, to the Board of Examiners for Speech-Language Pathology & Audiology, of all treatment records and documentation to assist with the investigation of this complaint.

____
Date

____
Patient Signature

____
Date of Birth

If patient is a minor ortherwise lacks capacity to sign:

____ ____________________
Authorized Person Other Than Patient Relationship

Note: If acting in capacity of legal guardian, attach copy of Power of Attorney, or other legal document

(Revised 09/11)

Board of Examiners for Speech-Language Pathology and Audiology
WEST VIRGINIA
1992
SEAL