

**STATEMENT OF COMPLAINT**



(FOR OFFICIAL USE ONLY)

--

COMMONWEALTH OF PENNSYLVANIA  
**DEPARTMENT OF STATE**  
Harrisburg

In order for the Department of State to initiate an investigation of possible violations of the licensing, registration, certification or notary commission laws and regulations of the Commonwealth by a licensee, registrant, certificate holder or notary commission holder of the Department, the complainant must complete both sides of this form. Complaints should be typewritten or clearly printed in black or blue ink. Please state the facts briefly and clearly, and be sure to submit any documents you have to support your complaint. Sign this form and return it to the Department of State, Complaints Office, P.O. Box 2649, 116 Pine Street, Harrisburg, PA 17105-2649.

**THIS FORM MUST BE SIGNED AND FILLED OUT COMPLETELY IN ORDER TO BE PROCESSED.**

**TYPE OF COMPLAINT (PLEASE CHECK ONE):**     NOTARY                       ATHLETIC COMMISSION                       CHARITY  
 PROFESSIONAL/OCCUPATIONAL LICENSE/CERTIFICATE/REGISTRATION                       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 support your complaint by appearing 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 support your complaint by appearing 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 8 1/2 x 11" paper.

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

**DEFENDANT 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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If additional space is needed, please attach 8 1/2 x 11" sheets.

**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:

RETURN COMPLETED FORM TO:

**Complaints Office  
Department of State  
P.O. Box 2649  
Harrisburg, PA 17105-2649**

**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:

