Rev. 05/2003

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, 2601 NORTH THIRD STREET, P.O. BOX 2649, 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? ☐ YES ☐ 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? ☐ YES ☐ NO		

***NOTE*: If additional witnesses are available, list names, addresses, and other pertinent data in a manner similar to above on 8 ½ 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		

H. FOR NOTARY COMPLAINTS ONLY:

Expiration date of notary's commission if known *(this date should appear on the notary's stamp, printed beneath the notary seal)*:	Date of transaction for which this complaint is being filed:

I. DESCRIPTION OF COMPLAINT.

Please describe your complaint in detail below. List services provided by the licensee, registrant, certificate holder or commission holder. Provide dates. List fees paid for notary services, if applicable. Attach copies of related documents and receipts obtained during the course of the matter if possible. If you need more space, please continue on page 4 of this form and/or use additional 8 ½ x 11" sheets of paper if necessary.

J. RESOLUTION.

How would you like this complaint to be resolved?

_____

_____

_____

_____

_____

_____

_____

If additional space is needed, please attach 8 ½ 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
2601 North Third Street, P.O. Box 2649
Harrisburg, PA 17105-2649
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
Date:

_____
Witness
Date:

DESCRIPTION OF COMPLAINT (CONTINUED FROM PAGE 2)

If additional space is needed, please attach 8 ½ x 11" sheets.

Please do not write in this space.