STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY ▪ GAVIN NEWSOM, GOVERNOR

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7857 www.bvnpt.ca.gov

CONSUMER COMPLAINT FORM

Please Print or Type

COMPLAINT REGISTERED AGAINST (LICENSEE)

1. Last Name (*Required*) | First (Required): | Middle Initial

Individual is licensed as (Check One): □ Licensed Vocational Nurse (LVN) □ Psychiatric Technician
License Number (if known) _____ _____

Business/Facility Name (Site Where Incident Occurred)

Licensee's Street Address: | City: | State: | Zip Code:

Licensee's Business Phone Number: ( ) | Licensee's Home Phone Number: ( )

Licensee Currently Employed By (if known):

PERSON REGISTERING COMPLAINT

2. Last Name | First (Required): | Middle Initial

Business/Facility Name

Street Address: | City: | State: | Zip Code:

Business Phone Number: ( ) | Home Phone Number: ( )

Your Relationship to Licensee:
□ Employer □ Staff Member □ Patient/Client □ Consumer □ Other (please specify):

Have you discussed this matter/complaint with the licensee? □ YES □ NO
When did the incident occur (specify date):

DETAILS OF COMPLAINT

3. **Describe events in the order they happened and provide the details of your complaint (i.e., Who, What, Where, When, Why and How. Also include copies of any relevant evidence/documents, list names of any witnesses and their telephone numbers.) Use reverse side or attach additional pages as needed.**

4. *I hereby certify under penalty of perjury under the laws of the State of California that to the best of my knowledge all of the statements contained herein are true and correct.*

Signature: Date:

DETAILS OF COMPLAINT (CONTINUED)

Complaint Registered Against (Licensee Name): *Person Registering Complaint (Your Name):*

RELEASE OF CONFIDENTIAL INFORMATION

If you are filing a complaint and you were the patient or if you are the patient's legal representative, the Board of Vocational Nursing and Psychiatric Technicians (Board) requests that you complete this "Release of Confidential Information" form in order to assist us in the investigation and adjudication of your complaint.

I, _____ , hereby authorize
(Complainant/Client/Patient – include date of birth*)

_____
(Person or entity and telephone number from which information may be obtained)

to disclose all records and information and answer any questions pertaining to the diagnosis and course of my (or patient's) treatment to the Board, any Board representatives, related local, state and federal governmental agencies, including, but not limited to, investigators and legal staff. I further agree to allow the Board, Board representatives and related governmental agencies, to process and possibly file other charges based on my complaint against:

_____
(If known, include name and/or license number of subject(s))

I understand that this information will be maintained in confidence, and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of California law and regulations. I also understand that the subject of my complaint (the licensee I'm complaining about) may receive a copy of my records pursuant to the Administrative Procedures Act.

This authorization shall be valid until the completion of the investigation and prosecution, including any investigation and preceding by another governmental agency that has requested your records and information.

_____ _____
Client Signature Date

OR:

_____ _____
Client's Representative/Relationship Date
(Attach written proof of authorization to act on client's behalf.)

***Date of birth is needed to positively establish the identity of the complainant/client.**