STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
Phone: (916) 263-7800 Fax: (916) 263-7857 Web: 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:

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DETAILS OF COMPLAINT (CONTINUED)

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