BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

STATE OF NEVADA

JULIE KOTCHEVAR, PH.D.
Administrator

LEON RAVIN, M.D.
Acting Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

COMPLAINT FORM

Please specify the type of complaint you are filing (check only one box):

☐ Licensed Dietitian
☐ Licensed Music Therapist
☐ Unlicensed Person Practicing Medical Nutrition Therapy
☐ Unlicensed Person Practicing Music Therapy

COMPLAINANT: (INDIVIDUAL FILING THE COMPLAINT)

Date: _____ NV License Number (if Applicable): _____

Your Name: _____

Your Address: _____

Your Mobile Number: _____ Alternate Number: _____

Your Email Address: _____

INFORMATION REGARDING INDIVIDUAL AGAINST WHOM THE COMPLAINT IS DIRECTED:

Name: _____ NV License Number (if Applicable): _____

Address: _____

_____

Telephone Number: _____ Alternate Number: _____

Email Address: _____

Web Address (if Applicable): _____

CLIENT/PATIENT INFORMATION (IF APPLICABLE):

Name: _____

Address: _____

Mobile Number: _____ Alternate Number: _____

Email Address: _____

Complainant's Relationship to Client: _____

Is the Client a Minor? ☐ Yes ☐ No If yes, please give age: _____

Your complaint is important to the Department of Health and Human Services so it is crucial to provide a clear and detailed statement of your complaint. Please be as specific as possible about your major concerns regarding the licensee or unlicensed person. You may attach supporting documentation such as canceled checks or receipts, charts, notes, advertisements, letters, brochures, etc.

Do you want to remain Anonymous? ☐ Yes ☐ No

(In order for this to remain confidential, information on the incident, client name and dates of incidents MUST still be provided for the Division to do a thorough investigation – If confidential, you will NOT be notified of the findings of the investigation.)

Date of Key Events: _____

Names of people who may have knowledge of the facts and circumstances, which are the basis of your complaint, and their contact information (mobile, email, or address):

_____

_____

Your knowledge of the facts and circumstances, which are the basis of the complaint you are making:

_____

_____

State the specific violations of concern:

_____

_____

_____

Have you contacted the person addressed in this complaint? ☐ Yes ☐ No

If yes, what transpired in the conversation?

_____

_____

Describe any other steps you have taken to resolve this complaint:

_____

_____

What action do you wish to see from this complaint?

_____

_____

I hereby certify that the facts set forth in this complaint are true to the best of my knowledge, or reasonably believed by me to be true. This complaint is drafted freely and voluntarily.

I understand that a copy of this complaint may be provided to the person who is the subject of this complaint. If the Division should find grounds for an Administrative Hearing, it may be necessary for you to appear as a witness under subpoena. Would you be willing to testify? ☐ Yes ☐ No

I wish to submit this complaint for review and request that I be notified at the conclusion of the investigation regarding the disposition of this complaint (if not filing anonymously).

_____ _____

Complainant's Full Name Printed Date

_____ _____

Signature of Complainant Email Address

This form cannot be emailed, please save and print.

MAIL TO: **OR** **FAX TO:**

THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
4220 SO. MARYLAND PARKWAY, SUITE D-810
LAS VEGAS, NV 89119

FAX: 702-486-6520

THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
727 FAIRVIEW DRIVE, SUITE E
CARSON CITY, NV 89701

FAX: 775-684-1073

Thank you for taking the time to complete this form. The Department of Health and Human Services appreciates your efforts in helping to protect the citizens of Nevada from harmful nutrition practices.