

STATE OF NEVADA

BRIAN SANDOVAL  
Governor

RICHARD WHITLEY, MS  
Director



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):

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

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State the specific violations of concern:

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

If yes, what transpired in the conversation?

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

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What action do you wish to see from this complaint?

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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.**