Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Aging and Disability Services Division
Helping people. It's who we are and what we do.

Dena Schmidt
Administrator

CONSUMER COMPLAINT FORM

Please return this form and any supportive documents to the address below (bottom of form).

☐Person receiving services ☐Parent of child receiving services ☐Professional Colleague ☐Other (Explain)

PERSON REGISTERING COMPLAINT		
Name	**Phone Number**	**Business Number**
Address (Number & Street):		
City	**State**	**ZIP**
COMPLAINT REGISTERED AGAINST		
Name	**Phone Number**	**Business Number**
Group/Hospital/Clinic		**License Number**
Address (Name & Street):		
City	**State**	**ZIP**

Please List all other organizations or agencies you have contacted relative to this complaint

1. _____
2. _____
3. _____

Please summarize the details of your complaint as clearly and as completely as possible. You may use the reverse of this form and/or additional sheets of paper.

_____
_____
_____
_____
_____

I certify that all information which I have given herein to be true, correct, and complete to the best of my knowledge.

I hereby authorize the Aging and Disability Services, Applied Behavior Analysis Board counsel or Board staff, to release information from this complaint to the LBA, LaBA, RBT, or entity who is the subject of my complaint. I understand that the Board will make every effort to remove material that I specifically request to have left out, but if that information is critical to the LBA, LaBA, RBT, or entity's understanding of my complaint against him/her, it will be released.

Signature _____ Date _____