

State of Ohio
Occupational Therapy, Physical Therapy and Athletic Trainers Board
Enforcement Division

Statement of Complaint

Directions: Persons interested in submitting a complaint against an individual licensed by the **Ohio Occupational Therapy, Physical Therapy and Athletic Trainers Board** should complete this form.

1. Include **copies** of any documentation you feel is relevant to your complaint.
2. Be sure to complete and sign the authority to release information form.
3. Include a list of names, addresses and telephone numbers of any individuals who have knowledge of the situation and/or witnessed the incident.

Personal Information:

First Name:	Middle Name:	Last Name:	
Mailing Address - Number & Street:		City:	
State:	Zip Code:	County:	
Telephone:	Cell Phone:	Alternate Telephone Number:	
Third Party Payor: (Worker's Compensation, Medicaid, Medicare, Private Insurer)		May this agency forward your complaint to your third party payor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dates Service Received From Licensee:	From:	To:	

Complaint Registered Against:

First Name:	Middle Name:	Last Name:		
Name of Employer:				
Address - Number & Street:		City:	State:	Zip Code:
Telephone:	Profession: <input type="checkbox"/> OT <input type="checkbox"/> OTA <input type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> AT		License Number:	

Action You Have Taken:

Have you voiced your complaint to the person, employer or facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the outcome?

Have you sought the assistance of an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give the full name, address and telephone number.

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Authority to Release Information

Directions: Complete the form and return along with the complaint form. Please be sure to sign, date and provide the name of the licensee or facility.

I, _____, hereby authorize release of information and medical records
(your name)
concerning my occupational therapy, physical therapy and/or athletic training treatment by

Company name: _____
Street address: _____
City, state and zip code: _____
Telephone: _____
Service provider name: (OT,PT, or AT) _____

to the Ohio Occupational Therapy, Physical Therapy and Athletic Trainers Board or its representative. The Board may, at its discretion, make copies of such information.

Name of client: _____
Date of birth: _____
Legal guardian: (if applicable) _____
Street address: _____
City, state and zip code: _____
Daytime telephone: _____
Signature: (client or guardian) _____
Date: _____
Witness signature: _____
Date: _____

• Inter office use only •

OTPTAT staff signature: _____
Date: _____