State of Nevada
Speech-Language Pathology, Audiology & Hearing Aid Dispensing Board

6170 Mae Anne Avenue, Suite 1, Reno, NV 89533-4540
(775) 787-3421 / Fax (775) 746-4105
https://www.nvspeechhearing.org Email board@nvspeechhearing.org

COMPLAINT FORM

PERSON FILING COMPLAINT (Complainant)

Name	Contact Phone
Company/Agency	Address, City, State, Zip

COMPLAINT FILED AGAINST (Respondent)

Name/License No.	Contact Phone
Company/Agency	Address, City, State, Zip

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

Company/Agency Name	Contact Address/Phone

Please summarize the details of your complaint as clearly and as completely as possible. Include names of all individuals who may have relevant knowledge or information regarding the circumstances or allegations contained in the complaint. You may attach additional pages as needed.

If Complaint is regarding the fitting and dispensing of Hearing Aids, please **attach a copy of the Sales Agreement** and complete the following, if applicable:

Date of Purchase of Hearing Aids: _____

Date Hearing Aids were received and Fitted into Ear(s): _____

Date Hearing Aids were Returned to Provider: _____

Date of Request for Refund from Provider: _____

Attach a copy of the response from Provider if applicable.

CERTIFICATION OF COMPLAINANT

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

Signature _____ Date _____

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Release of Medical Records

I, _____, hereby authorize any of the following: Physician, Psychologist, Health Professional, Hospital, Clinic, Hearing Aid Center, office or other related facility or provider to release information from my medical records to the State of Nevada, Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board at the above address.

It is understood that this release will be used in the following manner:

1. The information requested/received will be used only for the investigation of my complaint filed with, and in accordance with the authorized responsibilities of the Board, and;

2. All information may be released, including, medical and/or psychological, history, physical and/or mental condition(s), diagnosis, prognosis, treatment, laboratory reports, testing results, client records and all professional(s)'s notes.

3. This release shall be valid for one year from the date of signing.

4. A copy of this release is as valid as the original.

_____ _____
Date Signature of Patient/Client/Complainant

_____ _____
Date Signature of Parent/Guardian (if required)

_____ _____
Date Signature of Witness