



Maryland Board of Examiners of Psychologists
4201 Patterson Avenue
Baltimore, Maryland 21215-2299
Telephone No.: 410 764-4787
Fax No.: 410 358-7896

<i>Board Use Only</i>	
Date Received	_____
License Number	_____
Tracking Number	_____

Complaint Form

The Board of Examiners of Psychologists (the “Board”) is charged with qualifying, examining, and licensing individuals for the practice of psychology in Maryland. The Board also investigates and acts upon complaints against licensed psychologists and against individuals practicing under the supervision of licensed psychologists, such as psychology associates.

In order to protect the public, the Board urges you to file your complaint. Complete the following form and sign the affirmation. If information is requested that is unknown, please so state.

Please type the form or print **legibly**. In order to expedite the processing of your complaint, please ensure that all names, addresses and telephone numbers are correct. **If there is more than one psychologist or psychology associate involved in the complaint, please use a separate Complaint Form for each psychologist or psychology associate.**

Please understand that there is usually a considerable time lapse between the filing of the complaint and the disposition of the complaint. The Board must conduct a thorough investigation after which, if formal charges are issued, the case must proceed through the formal disciplinary process. You will receive periodic written updates as to the status of your complaint and the final disposition of the complaint.

DO NOT WRITE ON THIS PAGE

Please leave this cover sheet attached to your complaint form.

Notice of Confidentiality: The Board respects the confidential nature of psychological services and the privacy concerns of the consumers of those services. If a psychologist is charged by the Board with a violation of the laws or regulations of the Board, that psychologist has a right to know, unless circumstances warrant otherwise, the name of the complainant and the contents of this complaint form. Furthermore, if this complaint results in formal charges against the psychologist, the contents of this document may become a part of the official record in the case.

Complaint Form

1. *Your name in full* _____
2. *Home address* _____

3. *Business address* _____
4. *Home telephone number (including area code)* _____
5. *Business telephone number (including area code)* _____
6. *Email address* _____
7. *Are you 18 years of age or older?* *Yes* *No*
8. *Name of psychologist or psychology associate against whom you are registering this complaint:*

9. *Employment address of psychologist or psychology associate:*

10. *Telephone number of psychologist or psychology associate (including area code):*

11. *Check your relationship to the psychologist or psychology associate:*
 - Current patient or client*
 - Former patient or client*
 - Parent of minor child currently in treatment*
 - Parent of minor child formerly in treatment*
 - Other (Please describe):*
12. *Indicate what service(s) the psychologist or psychology associate was providing to you or to the patient?*
 - Individual therapy*
 - Group therapy*
 - Psychological evaluation*
 - Court ordered service(s) (Please describe):* _____
 - Other (Please describe):* _____

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13. List the beginning and ending dates of the time period when the services were provided:

14. List the addresses where the services were provided:

15. List the name, title or position, address and telephone number of any individual(s) who assisted in the investigation of the facts set forth in this complaint. If none, write "None."

16. List the name of any other official or organization with whom you have filed a complaint against this psychologist, either spoken, written, or online. Have they responded? What is the current status of that complaint? -If none, state "None."

17. Have you discussed your complaint with the psychologist or psychology associate in question?

Yes No

18. If you have discussed your complaint with the psychologist or psychology associate, briefly, what was his/her response?

19. List the name, address and telephone number(s) of any witness (es) having direct knowledge of this complaint, especially a witness who was present when the violation took place:

Complaint Form

20. *If this complaint is being filed by a person other than the patient/client and you are acting in an official or professional capacity, please furnish the following additional information:*

Your official title or designation _____

21. *Did you personally investigate the matter set forth in this complaint?* *Yes* *No*

22. *Do you have any reports or other written communications directed to you and/or your organization with respect to the matter(s) detailed here?* *Yes* *No*

If so, please attach that information to this complaint form.

THIS PAGE MUST BE COMPLETED FOR YOUR COMPLAINT TO BE CONSIDERED.

*23. Nature of Complaint: Please provide specific answers to the questions below
Please use additional pages if needed.*

1) In 25 words or less, what EXACTLY is your complaint?

2) Who is involved in the complaint? (Name all involved in the complaint)

3) When did the situation happen? (Include dates)

4) Where did the situation happen? (Include location/s)

5) Why did the situation happen? (Include events that led up to the situation)

6) How long did the situation go on?

7) Other pertinent information:

Complaint Form

(Continuation Page)

(Attach additional pages as necessary)

Complaint Form

24. Will you consent to the release to this Board or its designated investigating body the psychological or medical records that pertain to you or your minor child, or other records that you are legally authorized to release that pertain to the facts set forth in this complaint?

Yes No

25. If yes, please complete and sign the attached releases of information on pp. 8-9 (**YOU MUST PRINT ONE FORM FOR EACH HEALTH CARE PROVIDER**).

26. If no, please explain:

I HEREBY DECLARE AND AFFIRM under the penalties of perjury that the matters and facts set forth in the foregoing complaint are true and correct to the best of my knowledge, information and belief.

Signature of the Complainant

Date

Complaint Form

RELEASE OF MEDICAL AND PSYCHOLOGICAL RECORDS

I. _____
(Patient's Name)

of _____
(Patient's Address)

do hereby authorize _____ to release to the
(Psychologist or Health Care Provider)

Department of Health, Board of Examiners of Psychologists all records relating to the treatment and/or services provided to me during the period of _____ through _____, and permit discussion of the details of the treatment and/or service.

This release is valid for one year from the date below.

Signature

Date