DATE RECEIVED: _____ COMPLAINT NO.: _____

Kentucky Board of Interpreters for the
Deaf and Hard of Hearing
PO Box 1360
Frankfort, KY 40602
(502) 564-3296 Fax: (502) 564-4818
http://kbi.ky.ogv
10/2017

COMPLAINT FORM

This form should be completed and mailed to the address above. A videotape may accompany this form.

INFORMATION ABOUT YOU

Name _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone: Day (_____)_____ Evening (_____)_____

INFORMATION ON THE PERSON(S) YOU ARE COMPLAINING ABOUT

Name _____

Profession _____ Telephone (_____)_____

Place incident(s) Occurred _____

Address _____

City _____ State _____ Zip _____ County _____

Describe your complaint here. Be specific. What happened? When? Where? Use black ink or type. Use additional sheets if necessary. Please read instructions carefully before describing your complaint.

To the best of my knowledge, the information in this complaint is true and complete.
Check here if you have included additional sheets/material .

_____ Date _____
Signature

The above was signed and attested to be true and complete before me this ____day of

_____, 20_____.

Signature of Notary Public _____ Date _____

( ) Affix Seal Here

REQUEST TO REMAIN ANONYMOUS

_____(Mark for Request) I request to remain anonymous during the investigation and review of the complaint. I understand that even though my name and contact information will be redacted from the public copies of the complaint, I may be asked to submit to an interview with the board investigators and I shall be expected to participate in any future disciplinary hearing for the individual(s) or organization(s) named in my complaint. I further understand that, pursuant to the Kentucky Open Records Act, the public may access a copy of my complaint after a final decision has been issued by the board.

INSTRUCTIONS FOR COMPLETING THE COMPLAINT FORM

To complain about service by a professional licensed to practice by the Commonwealth of Kentucky, or about illegal practice of a profession by an unlicensed person, complete the COMPLAINT form above and send it to the Board at the address noted at the top of the form. Please note that we do not have authority to investigate fees that you believe are too high or to intervene in fee disputes. However, we can investigate complaints involving fraudulent billing.

Please note: complaints of misconduct concerning interpreters should be made to the Kentucky Board of Interpreters for the Deaf and Hard of Hearing, PO Box 1360, Frankfort, Kentucky 40602, (502) 564-3296.

Type or print clearly in black ink. Describe your complaint as completely as you can. If you do not have a daytime telephone number, it is helpful if you can provide a number where a message can be left for you during the day. If you have any papers which may support your complaint, such as bills or correspondence, please attach copies. Do not send originals. If you have physical evidence, it is important for you to retain that evidence in its original condition.

Be sure to sign and date your complaint. When your complaint is received, a copy, along with a letter from the Board requesting a response to the complaint, will be sent to the interpreter. When the response is received, the matter will be taken to the Board at its next regular meeting.

Also, complete the AUTHORIZATION form above by entering your name and the name of the interpreter and/or organization in the appropriate spaces. The Authorization directs the professional, organization, or facility to release information about the services rendered to you. Sign and date the Authorization, and have it dated and signed by a witness. A witness can be any person 18 years or older. The Authorization does not have to be notarized. A completed Authorization helps us investigate your complaint in a timely manner. If you do not want to complete the Authorization, you may leave it blank. However, leaving it blank may delay the investigation.

Authorization for Release of Medical and Business Records to the Kentucky Board of Interpreters for the Deaf and Hard of Hearing

I, _____, the undersigned, do hereby authorize the
full *(print name here)*
release of any and all medical and psychological records, billing information, and medical

and business reports from _____, Licensed/Certified Interpreter for the Deaf and Hard of Hearing, and/or any other licensed professional or practitioner, and the named interpreter, organization or facility and/or any organization of facility, to disclose fully to the Kentucky Board of Interpreters for the Deaf and Hard of Hearing (Board) and its authorized representatives all information and records. I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution against a licensed individual. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and KRS Chapter 13B, or other applicable law.

A photocopy of this authorization shall be deemed effective as an original.

This authorization shall be effective for one year from the date of signing.

_____ _____

Date

Signature of client, or parent/legal guardian if client is under 18 years of age

_____

Witness (Optional)