# Ohio Respiratory Care Board

## HME Division

77 South High Street, 16th Floor * Columbus, Ohio 43215-6108 * (614)644-4732 * Fax (614)728-8691

## HME FACILITY COMPLAINT FORM

| YOUR INFORMATION | |
|---|---|
| Name of person filing complaint | Home Phone |
| Address | Work Phone |
| City, State, Zip | Email Address |

| PATIENT INFORMATION | |
|---|---|
| Name of patient (if different from above) | Home Phone |
| Address | Work Phone |
| City, State, Zip | Email address |

| COMPLAINT INFORMATION | |
|---|---|
| Name of Facility being complained about | Phone Number |
| Address, City, State, Zip | |

**Please describe your complaint in detail.** Include all dates, prescription information (if applicable) and names of people involved. Use additional sheet if necessary

The above statements are true and accurate to the best of my knowledge. I understand the information may be used by the Ohio Respiratory Care Board in any way deemed necessary; including without limitation in any hearing under ORC Chapter 119 brought against the facility.

Your Signature Date