Telephone: (803) 896-4470
Fax: (803) 896-4656

South Carolina
Department of Labor, Licensing and Regulation

Office of Investigations and Enforcement
Board of Dentistry

Synergy Business Park
110 Centerview Drive
P.O. Box 11329
Columbia, South Carolina
29211-1329

Complaint Form

***Please type or print legibly*.**

Complainant

Name:_____

Address:_____
(Number and Street)

City: _____ State:_____ Zip Code:_____

Daytime Phone: (____)_____ Fax: (____)_____

Evening Phone: (____)_____

What is the best way to reach you? ☐ Daytime Phone ☐ Evening Phone ☐ E-mail: _____

Complaint Information

Board or Profession:_____

Name: _____
(Last) (First) (Middle Initial)

Business Name:_____

Address: _____
(Number and Street)

City: _____ State: _____ Zip Code:_____

Business Phone: _(____)_____

Please list all witnesses, providing names, addresses, and telephone numbers.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Statement of Complaint

Date and Location of Alleged Violation: _____

Please provide a statement of facts, allegations and/or, concerns. Attach a copy of each document you possess that can substantiate any facts in your complaint . These documents will not be returned. Please attach additional sheets, if necessary.

Have you attempted to contact the licensee concerning your complaint ___Yes ___No If yes, When?_____
What was the result?

I attest that the information provided is true, correct, and complete to the best of my knowledge.

_____ _____
Complainant Signature (Date)

_____ _____ _____
Notary Public (Expiration Date) (Date)

For Office Use Only

Date Received __/__/____ Receiving Board:_____
License Number_____ License Type_____
How Received _____ Date Reviewed __/__/____
Acknowledgement letter sent __/__/____ Category_____