Telephone: (803) 896-4470
Fax: (803) 896-4596

South Carolina
Department of Labor, Licensing and Regulation

Office of Investigations and Enforcement
Board of Long Term Health Care Administrators

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_____