MINNESOTA BOARD OF OCCUPATIONAL THERAPY PRACTICE

Protecting the Public

Complaint Registration Form

Your Information

Name:	
Home Mailing Address (City, State, Zip):	
Home Phone:	
Other Phone:	
E-Mail:	
Date of Birth:	
Is this complaint on your own behalf?	☐ Yes ☐ No

Occupational Therapist/Occupational Therapist Assistant Information

Name:	
Mailing Address (City, State, Zip):	
License Information (title and credential number if applicable):	
Web Address:	
E-Mail Address:	
Gender:	☐ Male ☐ Female ☐ Unknown ☐ Prefer not to disclose
Name of Practitioner's Organization or Business:	
Address of Practitioner's Organization or Business:	
Please check if you are: ☐ Licensee's Supervisor ☐ Provider ☐ Other Licensed Practitioner ☐ Agency ☐ Employer ☐ Client/Consumer ☐ Relative/Friend ☐ Other:	

Statement of Complaint

Provide a detailed description of the complaint with as much information as possible. If needed, you may attach additional pages. Please sign each additional statement of complaint page.

Signature: _____ Date: _____

MINNESOTA GOVERNMENT DATA PRACTICES ACT NOTICE:

The Minnesota Board of Occupational Therapy Practice (BOTP) is asking for information (data) about your complaint. The data you provide is voluntary. BOTP will use the data to investigate your complaint. According to the Government Data Practices Act, information gathered during the investigation is confidential. By completing and signing this document, you authorize BOTP, its agents, and/or agents of the Attorney General's Office representing BOTP to disclose the data to whom they reasonably believe need to know. BOTP may use the data in legal proceedings. After the investigation is closed, BOTP classifies the investigative data as private data pursuant to Minnesota Statute 13.41. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

NOTICE OF RIGHTS UNDER MINNESOTA DATA PRIVACY ACT

I understand that I am not legally required to complete or return this form. It is offered so that the Board may properly and thoroughly evaluate and investigate this complaint and if necessary, submit the information in any legal proceeding. Recognizing the Board's need to verify and, if necessary, legally pursue this complaint, I authorize the Board, its agents, and/or agents of the Attorney General's Office representing the Board to disclose this information to those whom they reasonably believe have a need to know.

AUTHORIZATION TO INFORM OCCUPATIONAL THERAPIST OF COMPLAINT

Having been informed of my rights under Data Practices Act,

I, _____, hereby authorize the Minnesota Board of Occupational Therapy Practice, its agents, or the agents of the Minnesota Office of Attorney General, to inform _____ of my complaint by providing this occupational therapist or occupational therapy assistant copies of my complaint documents.

_____ _____

Signature of Complainant Date

Records Waiver Authorization

TO: ANY OCCUPATIONAL THERAPIST, DOCTOR, HOSPITAL. CLINIC, OR OTHER INSTITUTION:

Having been informed of my rights under Minnesota Government Data Practices Act, I authorize you to furnish a copy of the below-named patient's records in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Occupational Therapy Practice, its agents, agents of the Attorney General's Office representing the Board, and any other appropriate state or federal governmental agencies.

I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records.

I release you, the Minnesota Board of Occupational Therapy Practice, its agents, and the agents of the Attorney General's Office representing the Board, from liability for so releasing said records or so testifying, and waive any privileges afforded me by the law relating to the disclosure or introduction into evidence of health information.

I also agree to permit, and hereby authorize the Board to use the records of the below named patient in any legal proceeding which may arise out of this matter.

A photocopy of this form is as valid as the original.

_____

Print or type Patient's Full Name

_____

Patient's Signature (or signature of legal guardian)

_____

Address

_____

Date Patient's Date of Birth