

## Advisory Board for Interpreters for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing or Oral Deaf Complaint Form

**INFORMATION ABOUT YOU:** In order to investigate your complaint, the following information must be provided. Upon receiving the complaint, the Advisory Board for Interpreters will send a letter verifying receipt of your complaint. You will be notified once action has been taken.

Name			
Mailing Address	City	State	Zip Code
Telephone Number(s): Home: (     )     ) Cell: (     )     ) VP: (     )     )		Email Address	

### INFORMATION OF INTERPRETER YOU ARE FILING A COMPLAINT AGAINST:

Name		Credential Held (if known)	
Mailing Address	City	State	Zip Code

### DETAILS OF COMPLAINT

Date of the Event	Place of the Event
Have you contacted the interpreter about your complaint?  _____ Yes                      _____ No	If Yes, when and how?
Did the interpreter respond?  _____ Yes                      _____ No	Was any action taken?
Did you complain to any other organization or entity?  _____ Yes                      _____ No	If yes, when?

Did the organization or entity take any action? If yes, what action was taken?

**ADDITIONAL WITNESSES (if any) - People who can provide information about the situation.**

Name

Contact Information

Type of Information to be shared?

Name

Contact Information

Type of Information to be shared?

Name

Contact Information

Type of Information to be shared?



By signing this grievance, I hereby certify that the information is complete and true to the best of my knowledge.

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Signature

Date

If you had assistance in completing this form, please give the name and contact information of the person who provided you assistance.

Name

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Contact Information

This form should be completed and mailed to:

Arkansas Department of Health  
Advisory Board for Interpreters  
4815 West Markham St., Slot 31  
Little Rock, AR 72205-3867