Arkansas Department of Health

COMPLAINT FORM
Radiologic Technology Licensure Program

501-661-2166 (Complaint Hotline)

COMPLAINANT INFORMATION (PERSON REPORTING)

Name: ……

Address: ……

Home Phone: ……**Work Phone:** ……..

LICENSEE INFORMATION (ALLEGED VIOLATOR)

Name: ……

Address: ……..
Street Address City State Zip

Home Phone: …… **Work Phone:** ……

CLIENT-PATIENT INFORMATION (IF APPLICABLE)

Name: ……

Address: ……
Street Address City State Zip

Home Phone: …… **Work Phone:** ……..

Complainant's Relationship to Client: ……

Is the client a minor? ☐ **Yes** ☐ **No** **If Yes, give age:** ……

SUPPORTING DOCUMENTATION

Attach documentation such as canceled checks or receipts, charts, notes, records; also names, addresses, and phone numbers of others who may have information about the alleged violations, etc.

DETAILS OF COMPLAINT

Dates of Client-Patient/Licensee Relationship: From: …… To: ……

Dates of Violations: ……

Details of Complaint: …….

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State of Arkansas County of _____ **_____**

Signature of Complainant

Mail your completed packet:

Department of Health
Radiation Control Section
Radiologic Technologist Licensure Program
5800 W. 10th Street
Freeway Medical Building, Suite 100
Little Rock, AR 72204