Advisory Board 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 between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing or Oral Deaf 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?	

BRIEF SUMMARY OF COMPLAINT - Please be as specific as possible regarding names, dates, locations, and actions that you believe to be improper, unethical, or in violation with Act 1314. You may use a digital taping and upload with complaint form or a link where to find the digital taping. You will still need to fill out all other sections of this form and sign it to be sent the Advisory Board of Interpreters. You may attach additional pages to this complaint form, if needed.

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

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

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