

Mississippi State Board of Chiropractic Examiners
P.O. Drawer 775
Louisville, Mississippi 39339
662.773.4478
662.773.4433 (FAX)

Complaint Form (please type or print legibly)

Your Name: _____

Your Street Address: _____

Mailing Address (if different): _____

Your Telephone: (home) _____ (work) _____

Name of person against whom you are complaining:

Name of Business and Street Address of person you are filing complaint against:

Nature of Complaint (attach additional supporting information in complete detail):

Witnesses (provide the names, addresses, and phone numbers of your witnesses, if any):

A. Name: _____

Address: _____

Phone: _____

B. Name: _____

Address: _____

Phone: _____

C. Name: _____

Address: _____

Phone: _____

Complaint Form

Page 2

By signing below, I do hereby consent to appear before the Mississippi State Board of Chiropractic Examiners and any court of law to testify to the allegations set forth in the complaint and I understand that the information becomes public record once filed with the Board.

I hereby authorize the Mississippi State Board of Chiropractic Examiners to take the following actions:

- 1) Talk to anyone who can provide information pertaining to my complaint;
- 2) Access and review any and all information regarding me and my treatment.

| | | |
|--------------------------|--------------|------|
| Signature of Complainant | Printed Name | Date |
|--------------------------|--------------|------|

Sworn to and subscribed before me this ____ day of _____, in the year ____.

Notary Public

S E A L

County of

State of

My Commission expires: