Creating a State of Health

PROTECTIVE HEALTH SERVICES

Oklahoma State Department of Health
Protective Health Services
Professional Counselor Licensing
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6030
FAX: (405) 271-1918
http:pcl.health.ok.gov

Clear Form

PROFESSIONAL COUNSELOR LICENSING COMPLAINT FORM

(Type or print legibly)

I, the undersigned, file a formal complaint with the Oklahoma State Department of Health against:

Name of Licensee/Candidate/Applicant: _____

Name of person making complaint: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____

Is the individual making the complaint a current or former client of the license/candidate/applicant?

❑ Yes ❑ Current ❑ Former Age at the time counseling services were rendered: _____

❑ No

If no, what is relation to the individual to whom counseling services were rendered?

_____

Name and Age(s) of the individual(s) to whom counseling services were rendered?

_____

_____

_____

_____

_____

If this complaint relates to and/or involves a court proceeding, please complete the following:

Style of case:_____ Case #/Forum: _____

Provide the complaint details on the reverse side of this form.

For Office Use Only:

Check appropriate license(s) or application: ❑ Professional Counselor ❑ Marital and Family Therapist ❑ Behavioral Practitioner ❑ Genetics Counselor ❑ Unlicensed

License Number(s) _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____

Describe your complaint in detail including the nature, frequency, duration, circumstances, and date(s) of the alleged violation. If you need additional space, please make copies of this page. If your complaint pertains to court testimony, please include a copy of the court transcript documenting the testimony in question.

The information given above and attached is true and accurate to the best of my knowledge. I realize the serious nature of filing such a complaint and recognize that the Oklahoma State Department of Health may not be able to take action without my cooperation in providing additional information if requested.

Signature of complainant: _____ **Date:** _____

RETURN TO: Oklahoma State Department of Health
Professional Counselor Licensing – 0504
1000 N.E. 10th Street
Oklahoma City, Oklahoma 73117-1299

OR **FAX TO:** **(405) 271-1918**