



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 \_\_\_\_\_

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Signature of Complainant

**Mail your completed packet:**

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