

South Dakota Board of Massage Therapy

Post Office Box 1062
Sioux Falls, SD 57101-1062
605/271-7103
doh.sd.gov/boards/massage

COMPLAINT FORM

PARTY AGAINST WHOM COMPLAINT IS MADE

Print Name _____

Address _____

License No. (if known) _____

PARTY MAKING THE COMPLAINT

Print Name _____

Address _____

Phone Number _____

License No. (if applicable) _____

NATURE OF COMPLAINT (State clearly and specifically, all charges made against party named above. Be it known, your complaint will be sent to the licensee named above for his/her response.)

Will you, as the Complainant, willingly testify if a hearing should be called by the SD Board of Massage Therapy for the purpose of pressing charges arising from this complaint? _____
(Yes or No)

I hereby certify that the above stated charges are true and correct to the best of my knowledge. Further, I waive any requirements of confidentiality, and authorize disclosure of information as the Board or its staff deem necessary to investigate or pursue this complaint.

Signed _____
(sign before a Notary)

Before me personally appeared _____ whose signature appears above, and made oath and says that he/she is the identical person making this complaint and that all the foregoing statements are true and correct.

My commission expires _____
(seal)

Notary Public Signature