

RIBCCDP ETHICAL COMPLAINT FORM

Please fill in the Complaint Form completely, sign and date the form. Please be as clear and concise as possible. Type or print all information in black ink. Incomplete information may delay the investigation of your complaint.

Patient/Complainant Information

Name of Patient _____, _____ MI Suffix
Last First

Date of Birth ____/____/____

Address _____

Phone Number (____) ____ - _____

ACDP II, ACDP, CDCS, CIT, CDP, PCDP, SAC, CPS, ACPS, ACPS, CPSS, CCJP, RCS, CCDPD, CCDP

Name of Professional: _____, _____ MI Suffix
Last First

Address _____

Phone Number (____) ____ - _____

Facility _____

Address _____

Phone Number (____) ____ - _____

Complaint Information

Please attach a brief (1-2 page) summary of your complaint(s), then sign and date the Verification Statement below:

Verification Statement

I hereby verify that the attached statements in this complaint are true and accurate to the best of my knowledge and recollection and do affirm that this complaint is filed in good faith.

Complainant Signature

____/____/_____
Date of Signature

Please enclose all copies of any pertinent information/documentation related to your complaint. Mail the completed Complaint form, Summary of Complaint, signed Release of Information Form and signed Verification Statement along with any other documentation to:

**Rhode Island Board for Certification of Chemical Dependency Professionals
31 Smith Avenue – 3 Rear
Greenville, RI 02828**