Arkansas Dietetics Licensing Board
5800 W. 10th St. Suite 103
Little Rock, AR 72204
Phone: (501) 661.2530
Arkansas Dietetics Licensing Board Arkansas Department of Health
ardiet@arkansas.gov

FOR BOARD USE ONLY:
Date Received: ______________

Complaint Form

Return the completed forms via mail to the Board office address or via email to the Board email address. Please attach any documents concerning the allegation.

Complainant Information (person making allegation)

Name: ____

Address: ____

City: ______________________ State: __________ Zip: __________

Phone: __________________ Email Address: ______________________

Dietitian Information (person(s) against whom the allegation is made)

Name: ____

Address: ____

City: ______________________ State: __________ Zip: __________

Statement of your Complaint (use additional pages if necessary)

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Date: ______________ Signature: ______________________________

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Authorization to Release Complaint Information

I hereby give the Arkansas Dietetics Licensing Board permission to send a copy of my complaint to the dietitian in which allegations have been made. This will include disclosing my identity.

I agree to testify at any hearing which may arise as a result of this allegation. The statements I have made are true and correct to the best of my knowledge and belief.

I hereby authorize all hospitals, institutions, dietitians, physicians, clinics, employers (past and present), laboratories, insurance companies, and/or all government agencies to release to the Arkansas Dietetics Licensing Board or its representatives, all information, records, files, or documents in whatever form pertaining to information in their possession, or control. A copy of this release may be used by the Board in place of the original.

Understanding the above, by my signature below, I hereby give consent to the Board to release a copy of my complaint.

Complainant (print name): ____

Complainant Signature: ______________________________ Date: ________________

BOARD USE ONLY – DO NOT WRITE BELOW THIS LINE

To: ____

Address: ____

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

___Consultation ___History ___Progress Notes ___Laboratory / Pathology Reports

___Clinical Findings ___Orders / Recommendations ___Other___________________________

Please send information to:

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