

**Department of Health and Hospitals – Office for Addictive Disorders
Addictive Disorder Regulatory Authority
(ADRA)**

COMPLAINT FORM

Date: _____

COMPLAINANT

Name: _____

If an organization, list name and title of a person to represent the organization.

Representative: _____ Title: _____

Address: _____

Phone: Day: (____) _____ Evening (____) _____

SUBJECT

Name: _____

If an organization, list the name and title of a person who could be contacted.

Contact: _____ Title: _____

Address: _____

Phone: Day: (____) _____ Evening (____) _____

ALLEGED VIOLATION
