DATE RECEIVED: _____
COMPLAINT NO.: _____

Commonwealth of Kentucky
Board of Interpreters for the
Deaf and Hard of Hearing
P.O. Box 1360
Frankfort, KY 40602
Ph: 502-892-4252
Fax: 502-564-4818
KBI@ky.gov

COMPLAINT FORM

DPL-KBI- 09
Rev. April 2024
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KRS 309.304(6) & 309.316
201 KAR 39:100

NOTE: This form should be completed and mailed to the address above. Please read the instructions (located on Page 3) carefully before describing your complaint.

Are you deaf or hard of hearing and would like to request a reasonable accommodation for the submission of a complaint? If yes, please complete Section 1 and Section 2 as well as sign the affidavit at the end. Once we receive the complaint, the Board Administrator will contact you to set this up.	❑ **YES** ❑ **NO**

SECTION 1- Information About You

(TYPE OR PRINT ALL INFORMATION)

Last Name	**First Name**	**Middle Name**

Mailing Address

Street or P.O. Box:

City: **State:** **Zip:** **County:**

Email	**Phone Number** (including Area Code)

SECTION 2-
Information on The Person(s) You Are Complaining About

Last Name	**First Name**	**Middle Name**	**Profession/License Number**

Mailing Address

Street or P.O. Box:

City: **State:** **Zip:** **County:**

Telephone Numbers (including area code)	**Place Incidents(s) Occurred**
Cell: **Home:**	

SECTION 3- Complaint Details

DATE RECEIVED: _____, 2024 COMPLAINT NO.: _____

Describe your complaint here. Be specific. (What happened? When? Where?) Use additional sheets if necessary. Please read the instructions carefully before describing your complaint.

To the best of my knowledge, the information in this complaint is true and complete.

Signature: _____ Date: _____

DATE RECEIVED: _____, 2024 COMPLAINT NO.: _____

INSTRUCTIONS FOR COMPLETING THE COMPLAINT FORM

To make a complaint about misconduct or other interpreting services provided by an individual licensed by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing (the "Board"), or about interpreting services provided illegally by an unlicensed person, complete the COMPLAINT Form above and send it to the Board at the address listed at the top of the form. Please note that we do not have authority to investigate costs for services that you believe are too high or to intervene in fee disputes. However, we are authorized to investigate complaints involving fraudulent billing.

Type or print clearly in black ink. Describe your complaint as completely as you can. If you do not have an email address and/or a daytime telephone number, please provide a number where a message can be left for you during the day. If you have any papers or other evidence that may support your complaint, such as billing invoices or correspondence, please attach copies. **Do not send originals.** If you have physical evidence, you need to retain that evidence in its original condition.

Be sure to sign and date your complaint. When your complaint is received, a copy, along with a letter from the Board requesting a response to the complaint, will be sent to the interpreter. When the response is received, the matter will be taken to the Board at its next regular meeting.

Also, you must complete the AUTHORIZATION form below by entering your name and the name of the interpreter and/or organization in the appropriate spaces. The Authorization directs the professional, organization, or facility, if any, to release information about the services rendered to you. **Sign and date the Authorization, and have it signed and dated by a witness.** A witness can be any person 18 years or older. The Authorization does not have to be notarized. A completed Authorization assists with the investigation of your complaint in a timely fashion. If you do not wish to provide the Authorization, you may leave it blank. However, failure to provide the Authorization may result in a delay of the investigation.

DATE RECEIVED: _____, 2024 COMPLAINT NO.: _____

Authorization for Release of Medical and Business Records to the Kentucky Board of Interpreters for the Deaf and Hard of Hearing

I, _____, the undersigned, do hereby authorize the full
(print name here)
release of any and all medical and psychological records, billing information, and medical

and business reports from _____, Licensed/Certified Interpreter for the Deaf and Hard of Hearing, and/or any other licensed professional or practitioner, and the named interpreter, organization or facility and/or any organization of facility, to disclose fully to the Kentucky Board of Interpreters for the Deaf and Hard of Hearing (the "Board") and its authorized representatives all information and records. I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution against a licensed interpreter. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and KRS Chapter 13B, or other applicable law.

A photocopy of this authorization shall be deemed effective as an original.

This authorization shall be effective for one year from the date of signing.

_____
Signature of client, or parent/legal guardian if client is under 18 years of age.

_____
Date

_____
Witness (must be 18 years of age or older)

_____
Date