

Health Occupations Program PO Box 64882 Saint Paul, MN 55164-0882 (651) 201-3731 TDD: (651) 201-5797

For office use only

(rev.070710)

Minnesota Body Art Complaint Form

Allegation ID #	(to be filled	(to be filled out by MDH)					
Please complete this form and return it to the address above. Please type or print clearly, using black ink. The information you provide will be analyzed and an investigation conducted, if warranted. You will be contacted if additional information is needed and when the investigation concludes.							
Information about the Person Making the Complaint:							
Your Name:							
First		Middle	Last				
Your Address:							
	Street						
City	State	Zip	County				
Your Telephone Number: (Area) a Code Number						
Your E-mail Address:							
Is this complaint on your own be	ehalf? Yes No	(circle one)					
If no, please provide the following	ng information about the	consumer for whon	n you are filing this complaint:				
Information about the Co	onsumer:						
First	Middle		Last				
Consumer's Address:							
		Street					
City	State	Zip	County				
Consumer's Telephone Number	r: () Area Code Numb	er					

Consumer's E-mail Addre	ess:				
Is Consumer a Minor? Y	es / No If Yes, Consu	ımer's Birth Da	te	// _ Day	Year
Your relationship to the consumer: ☐ Parent/Guardian ☐ Relative ☐ Another technician ☐ Government Agency ☐ Friend ☐ Technician self reporting ☐ Technician's supervisor ☐ Medical Professional ☐ Anonymous ☐ Other					
Information About t	he Subject of the	Complaint:			
What is the Complaint Ab	oout? (Circle as Approp	riate) Tech	nician	Establishment	Both
What Type of Body Work	Is Involved? (Circle as	Appropriate)	Tattoo	Piercing	Both
Nature of Complaint: (Circle as Appropriate) Injury Procedure on Minor					
Unsanitary Procedure I	Jnsanitary Shop	Unlicensed P	ractice O	ther	
Technician's Name:	First	Middl		Last	
Taskaisiania Candau (Ci				Lasi	
Technician's Gender: (Circle One) Male Female					
Where Was the Body Art Performed: (Circle One)		e) Estab	lishment	Residence	Other
If Other, please explain: _					
Establishment Name:					
Street Address:					
City	State		Zip	County	
Technician/Establishment Telephone Number: () Area Code Number					
		/ II Ca Code	Number		

TENNESSEN WARNING

Minnesota Government Data Practices Act (MGDPA) Notice: Information you give to MDH as part of an active investigation of a complaint against a technician and/or establishment is confidential. MDH will use such information to evaluate the complaint and, if necessary, bring legal action against the technician and/or establishment. In some circumstances, investigative information received from you about a technician and/or establishment may be disclosed to certain other persons or entities, including the Attorney General's Office, the Office of Administrative Hearings, any subsequent reviewing court, and any other government agency deemed necessary by MDH. Under the MGDPA, as a consumer, you are not required to cooperate with the MDH. However, your lack of cooperation could hinder MDH's ability to investigate the matter. Technicians and establishments licensed by MDH are required by statute to cooperate with an MDH investigation. A practitioner who refuses to cooperate may be subject to disciplinary action. Once an investigation is closed, the investigative data is classified as private data pursuant to Minnesota Statute 13.41. Orders for hearing and specification of a final disciplinary action are public data pursuant to Minnesota Statute 13.41.

NARRATIVE DESCRIPTION OF COMPLAINT

name and contact information of ar have additional information. You madditional sheet. Enclose with your limited to: medical records, receipts and any other documentation you be warning included in this packet.	ny individual who either r nay use additional sheets complaint copies of any s, photographs, aftercare pelieve is related. Your r	may have witnessed the ling in however, if you do, plead documentation you have a instructions, business contacts.	boody art procedure or ase sign and date eacl e including, but not ards, advertisements,
Signature:	D	ato:	

Client Records Waiver Authorization

(Please complete, sign and date)

TO:provider)	(Client's physician, clinic, or applicable
Having been informed of my rights under Act, I authorize the Body Art Establishme records in their possession, to allow thos MDH, and any other appropriate state or authorize the Body Art Establishment and any and all of their findings and/or the promoted by MDH, its agent(s), and the agent(s) of the from liability for so releasing said records	e records to be inspected and/or copied by the
has been taken in reliance on this conseconsent is revoked upon conclusion of M	ation at any time except to the extent that action nt. Unless express revocation is made, this IDH's investigation. A photocopy of this release ree to permit and hereby authorize MDH to use ceeding arising out of this matter.
Date:	
Name: (please print)	
Signature:	
If not signed by the consumer named in to	this complaint, what is your relationship to the