



**COMPLAINANT INFORMATION**

NAME (FIRST)		MIDDLE INITIAL	LAST		
STREET		CITY	COUNTY	STATE	ZIP
HOME TELEPHONE	WORK TELEPHONE	FAX	E-MAIL ADDRESS		
ASSOCIATION WITH SCHOOL (CUSTOMER, EMPLOYEE, ETC.)					

**SUBJECT OF COMPLAINT**

<input type="checkbox"/> Individual	<input type="checkbox"/> School	DATE OF INCIDENT
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Please describe the complaint in detail. Attach any additional documents to the back of this form.

Are you willing to testify if necessary?  Yes  No  
Are you willing to provide an affidavit if necessary?  Yes  No

I understand that a copy of this form and any or all of the enclosed information may be shared with the business or individual on page one of this form *if a hearing is held to resolve this complaint*. In addition, I understand that the complaint *may* be disclosed if it is the subject of a subpoena or Public Records request, and that the Department of Public Safety will not disclose the complainant's personal information, other than name, unless compelled to do so by a subpoena or court order.

COMPLAINANT'S SIGNATURE <b>X</b>	DATE
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\*Please complete and mail or fax this original document with all necessary attachments to:  
Ohio Department of Public Safety  
Driver Training  
P.O. Box 182081  
Columbus, Ohio 43218-2081  
Fax: (614) 728-8330

**OFFICIAL USE ONLY**