



COMPLAINANT INFORMATION

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

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.

Yes No Are you willing to testify if necessary?

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

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 X	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) 752-8027

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