ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Hearing Instrument Consumer Protection Program
HEARING INSTRUMENT COMPLAINT FORM

PLEASE PRINT NAME OF COMPANY/PERSON AGAINST WHOM THE COMPLAINT IS BEING FILED:

Name of Person _____

Name of Business _____

Address _____ City _____

State _____ ZIP _____ County _____ Phone (_____)_____

Your Name (Please Print) _____

Your Address _____ City _____

State _____ ZIP _____ County _____ Phone (_____)_____

PLEASE PRINT YOUR COMPLAINT BELOW INCLUDING IMPORTANT DETAILS IN THE ORDER IN WHICH THEY HAPPENED; INCLUDE DATES AND NAMES.

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(Use additional sheets, if necessary)

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CIRCLE YOUR RESPONSE

1. YES NO Did you sign a contract? If yes, please give date the contract was signed _____. Please include a copy of your contract with the complaint.

2. YES NO Have you contacted the business about your complaint? If YES, to whom did you speak? _____

3. YES NO Has the business made any effort to solve your problem? If YES, what have they done? _____

4. YES NO What would resolve this issue for you? What do you want? _____ _____

5. YES NO Did you give the dispenser a statement from a physician that said your hearing had been medically evaluated and you were a candidate for a hearing instrument?

6. YES NO If you answered NO to question #4, did the dispenser tell you that signing the waiver was not in your best health interest?

7. YES NO Did you receive a written statement from the dispenser that told you to call the Illinois Department of Public Health if you had questions or concerns?

8. YES NO If legal or administrative action is taken, will you be willing to testify?

9. Did this sale take place in your home or in the office? _____

THE ABOVE COMPLAINT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HAVE NO OBJECTION TO THE CONTENTS BEING FORWARDED TO THE PERSON WHOM THE COMPLAINT IS AGAINST. FURTHER, I REQUEST THAT THE INFORMATION CONTAINED IN MY FILE WITH _____ BE RELEASED TO THE DEPARTMENT.
(Dispenser/Business Name)

_____ _____
Signature Date

NOTE: Please enclose copies of pertinent papers, contracts, documents and receipts relating to your hearing instrument transaction. Do not enclose originals.

PLEASE RETURN THIS FORM ALONG WITH COPIES OF ALL YOUR PAPERWORK TO:

Illinois Department of Public Health
Hearing Instrument Program
535 W. Jefferson St., Third Floor
Springfield, IL 62761
Telephone: 217-524-2396
FAX: 217-524-4201
E-mail: dph.visionandhearing@illinois.gov