

**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.

(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