



## **Counselor, Social Worker & Marriage and Family Therapist Board**

77 S High St., 24th Flr, Rm 2468  
Columbus, Ohio 43215-6171  
614-466-0912 & Fax 614-728-7790  
[www.cswmft.ohio.gov](http://www.cswmft.ohio.gov)

### **Investigation/Complaint Information**

**Please read the following information carefully prior to filing your complaint and retain this page for future reference. Depending on the complexity of the complaint, the investigative process may take a few months, up to a year or longer to complete. Your patience is appreciated during this process.**

1. Investigations are confidential. Immediately after receipt of a formal written complaint an acknowledgment letter will be mailed to the complainant. When an investigator is assigned to the complaint, they may or may not contact you for supplemental information. You may be asked to provide further information, such as documentation, physical evidence, or clarification of the information that you have already provided. Interviews are conducted with the complainant when deemed necessary.
2. The investigator may interview the licensee or applicant, and employer(s), in addition to obtaining documentation and records. Complaints and/or investigations are not public information- investigations are confidential. Upon completing an investigation the investigator prepares an investigative summary of the case. The investigation may take as little as a few weeks or several months, and varies case by case.
3. An Investigative Liaison (Board Member) will review and make a recommendation such as: close unsubstantiated, close with caution, or formal discipline such as a consent agreement (suspension, ethics, supervision, revocation, etc.), or the liaison may even ask for additional information from the investigator. The Investigative Liaison and Deputy Director review the cases.
4. When the professional standards committee meets, the Deputy Director presents the recommendation of the Investigative Liaison. The committee then will vote to accept the recommendations.
5. When an investigation indicates that a violation appears to have occurred and formal action is required the board may seek to negotiate a Consent Agreement, which must be approved by both the licensee/applicant and the Board. The licensee has the option to accept the consent agreement terms or reject them. The consent agreement usually contains the applicable regulatory language, and any disciplinary action(s) agreed upon. The Board will approve the consent agreement at the first regularly scheduled meeting following receipt of the signed consent agreement. Disciplinary action is posted on the board's website, and reported to the national practitioner data bank. *(The committee does not offer a consent agreement in all cases; some may go directly to a Notice of Opportunity for Hearing.)*
6. If an amenable Consent Agreement is not reached with the licensee/applicant and the Board, the Board may file formal charges, which are presented in a document titled "Notice of Opportunity for Hearing." If the Board approves such charges, the licensee/applicant may request a public administrative hearing.
7. If an administrative hearing is scheduled, you may be subpoenaed as a witness to provide testimony. In such a case, the Assistant Attorney General assigned to the Board will assist and guide the preparation of witness testimony and presentation of documentation. The licensee/applicant also has the right to call witnesses and present evidence and examine the complainant.
8. All testimony and evidence used during a formal administrative hearing is considered a public record. The public record can be viewed by any individual who requests to do so. Medical records (including mental health treatment records) are typically protected and will not become a public record unless under order of a court.
9. As a result of the hearing the Board may determine what disciplinary action may be required/appropriate to address, if any. The licensee/applicant has the right to appeal the Board's decision through the courts.
10. Complainants, and licensees/applicants, are notified in writing regarding the outcome of the investigation after the Board decision.
11. Board meetings are held every other month beginning in January; dates are posted on the Board's website. The Professional Standards Committee meetings usually begin at 9 a.m. on Thursday and Friday, and the full Board meeting is usually at 1 p.m. on Friday. Board meetings are open to the public.



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## **Statement of Complaint**

Directions: This form is for use by any person interested in submitting a complaint against a licensee or registrant of the Counselor, Social Worker, & Marriage and Family Therapist Board.

- Include copies of any documentation you feel is relevant to your complaint
- Complete and sign the release included. The release will allow the Board to speak to the licensee about your concerns and give the Board access to your client file, if applicable.
- Include names, addresses and telephone numbers of any individuals who have knowledge of the situation. The Board may communicate via email whenever possible.

### **1. Complaint Against:**

Name: \_\_\_\_\_  
(Counselor, Social Worker, or Marriage and Family Therapist)

Agency/Employer/Name of Practice: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ Email: \_\_\_\_\_

License #: (If known) \_\_\_\_\_

### **2. Complaint Filed By:**

\_\_\_ Client/Patient    \_\_\_ Family/friend    \_\_\_ Self-report    \_\_\_ Licensed Professional  
\_\_\_ Agency    \_\_\_ Insurer    \_\_\_ Other (please describe) \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

### **3. Action You Have Taken:**

Have you voiced your complaint to the employer or facility and/or followed their internal grievance process? If yes, what was the outcome?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you sought the assistance of an attorney or obtained a second opinion from another mental health professional? If yes, please give the full name address and telephone #:

\_\_\_\_\_  
\_\_\_\_\_

Action you would like the Board to take? \_\_\_\_\_



**Authorization for Release of Information**

1. Patient Name: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. I authorize: (Practitioner/Agency Name) \_\_\_\_\_

To release information to:

The State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board  
77 S High St., 24th Flr, Rm 2468  
Columbus, OH 43215-6171  
Telephone (614) 466-0912 Fax (614)728-7790

4. Date(s) of service (Month, Day & Year to the best of your knowledge): \_\_\_\_\_

5. **Specific information to be released** (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> History & Physical Exam               | <input type="checkbox"/> 3 <sup>rd</sup> Party Correspondence     |
| <input type="checkbox"/> Psychiatric/Mental Health Evaluations | <input type="checkbox"/> Consent for Treatment                    |
| <input type="checkbox"/> Treatment Plan                        | <input type="checkbox"/> Custody/Parenting Documentation          |
| <input type="checkbox"/> Progress Reports                      | <input type="checkbox"/> Correspondence with Attorneys/GAL/Courts |
| <input type="checkbox"/> Discharge Plan                        | <input type="checkbox"/> Other (specify): _____                   |

6. Reason for disclosure: \_\_\_\_\_

7. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Parent/Legal Guardian)

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Your healthcare or payment for care will not be affected by whether you sign this authorization. A photocopy or facsimile of this authorization will have the same authority as the original.

**Revocation of Release of Information:**

I hereby withdraw my consent for this release of information:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Parent/Legal Guardian)