Bureau of Community and Health Systems
PO Box 30664 ● Lansing, MI 48909
Telephone: (517) 335-1980
www.michigan.gov/bchs
LARA-BCHS-Qualified-Interpreter@michigan.gov

Office use only #

STATEMENT OF COMPLAINT

DEAF, DEAFBLIND AND HARD OF HEARING QUALIFIED INTERPRETERS

Authority: 1982 PA 204 (MCL 393.501 et seq.) and R 393.5001 et seq.

The Bureau has jurisdiction over only certain matters involving qualified interpreters in the Deaf Persons' Interpreters Act. If there is jurisdiction over your complaint, an investigation will be conducted for possible action. A person may file a grievance with the Bureau against a qualified interpreter within 90 calendar days of an alleged violation of the act or rules. All complaints shall be filed in writing. As an accommodation, a D/DB/HH person may file a video request (enclosed on a flash/thumb drive if submitting by US mail or a video file attached to an email) so that it may be translated by the Bureau into writing.

Complaints related to denial of reasonable accommodations may be filed with the Michigan Department of Civil Rights under the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101 to 37.1607, or with the United States Department of Justice for violations under the Americans with Disabilities Act of 1990 or Americans with Disabilities Amendments Act of 2008. R393.5061. A person may file a grievance by contacting the Michigan Department of Civil Rights, Division on Deaf, Deafblind and Hard of Hearing, either through VP at 313-437-7035 or email at DODDBHH@michigan.gov.

YOUR COMPLAINT IS AGAINST	**INFORMATION ABOUT YOU**
Name of Individual/ Qualified Interpreter	Name
Address (Number and Street)	Address (Number and Street)
City/State/Zip	City/State/Zip
Telephone number	Telephone number
E-mail Address	E-mail Address
Certification Number (If known)	Are you willing to testify in a hearing? Yes No

Briefly explain your complaint below. Attach additional sheets, if necessary, to clearly document the violations which you believe have occurred.

LOCATION AND DATE OF INCIDENT: List full name of agency/business/company/hospital/public facility/school/entity where the incident occurred.
Name:
Address: **E-mail:**
Date(s)/Time(s) the incident(s) occurred:
POTENTIAL WITNESSES: Provide names and contact information individuals who may have witnessed the events which resulted in this complaint, if applicable
Name: **Telephone:** **Email:**
Name: **Telephone:** **Email:**
I understand the information provided will not be returned, will be used for investigative purposes, and may be subject to release under the Freedom of Information Act. **_____ _____** **Signature Date**