**DIVISION OF LICENSING AND PROTECTION**

Survey and Certification Reporting Form

**NOTE: \*=required field**

Please fill out this form, save it and attach and send through email to: AHS.DAILSCIntake@vermont.gov or by fax: (802) 241-0383. (email preferred)

**PLEASE CHECK ONE\*:**

Complaint [ ]  Facility self-report [ ]

**Facility/Agency Name\***Click here to enter text.

**CONTACT INFORMATION:**

**Reporter/Complainant Name\***: Click here to enter text.

Reporter/Complainant Mailing Address: Click here to enter text.

**Reporter/Complainant Phone Number\*:** Click here to enter text.

Reporter/Complainant email (if applicable): Click here to enter text.

**RESIDENT/PATIENT/CLIENT INFORMATION (if applicable)**

Name: Click here to enter text.

Mailing address if other than facility: Click here to enter text.

Relationship of reporter to resident/patient/client: Click here to enter text.

**DESCRIPTION OF INCIDENT/COMPLAINT\***: \**Describe in detail your concerns, include as much information as possible, including any persons that may have been involved. If you run out of room, you can attach a separate page with additional information.*

Click here to enter text.