

COMPLAINT / INTAKE FORM

SOURCE NAME: _____

STREET: _____

CITY: _____

PHONE: _____

SOURCE [] IS [] IS NOT willing to be identified and appear as a witness as necessary.

COMPLAINT ALLEGES:

NAME: _____

STREET: _____

CITY: _____

PHONE: _____

[] ON _____

[] DURING PERIOD _____

DID

AT

CORROBORATING
FACTS:

LICENCE NO.: _____

EXPIRATION: _____

LIABILITY INS: _____

BONDING: _____

WORKERS' COMP: _____

REFERRED TO: _____

ON DATE: _____

REMARKS:

Please direct completed Complaint Form to:

Al Nagel
State of Alaska
Department of Labor &
Workforce Development
3301 Eagle Street, Suite 302
Anchorage, AK 99503

Phone: (907) 269-4925
Fax: (907) 269-4932
Email: al_nagel@labor.state.ak.us