Kentucky Cabinet for Health and Family Services
Office of Inspector General – Division of Health Care

Illegal Health Care Facility/Service Reporting Form

Required information to file a complaint is denoted with an asterisk (*).

Reporting Source contact information (can be anonymous):

Name:_____

Address:_____

_____

Phone number(s):_____

***Name of Facility/Service/Individual providing health care services:** _____

***Address of Facility/Service:** _____

***Description of health care services provided:**

_____

_____

_____

***Resident(s)/Patient(s)/Client(s) name or description of the person(s) involved:**

_____

Type of professional staff providing services: _____

Facility/Service/Individual providing health care services contact phone number(s): _____

_____