



# LICENSING COMPLIANCE COMPLAINT

State Form 49117 (R2 / 1-24)

## OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

FAMILY SOCIAL SERVICES ADMINISTRATION

Name of facility/ provider?	Date received (month, day, year)	Time received
Location address of program: (N and street, city, state, ZIP code) *Required	Name of complainant	
	Complainant address (number and street, city, state, ZIP code) *Optional	
Telephone number	Complainant Electronic address:	
County	Complainant Telephone number	
Facility identification number if available:	Relationship to facility (parent/consumer/neighbor, etc.)	
Does the program accept CCDF/PTQ/OMW Program?	Does constituent wish to have a follow up communication after completion of complaint? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> Email or <input type="checkbox"/> Phone call	

**Type of facility:**

<input type="checkbox"/> Unlicensed/ Not Regulated Home	<input type="checkbox"/> Unlicensed/ Not Regulated Center
<input type="checkbox"/> Licensed Child Care Home	<input type="checkbox"/> Licensed Child Care Center
<input type="checkbox"/> LLEP Home/ Nanny Care (exempt)	<input type="checkbox"/> LLEP Center (exempt)
<input type="checkbox"/> CCDF Issue	<input type="checkbox"/> Unregulated Business practices
<input type="checkbox"/> Self-report from program's Designee	<input type="checkbox"/> Unlicensed Registered Child Care Ministry

### Detail Extract of Complaint

(Be precise. Give date and times of incident, staff or children involved, number each item. List only item(s) in violation of child care law or regulation.)

Days/ dates on which the program operates (Helps us to be precise when scheduling an inspection)

Do you know what time of day that the incident occurred? (Helps us to be precise when investigating)

Name of child or children involved. (Helps us to be precise when investigating or review of files)

Age/s of child/ren involved.

Name of staff/volunteer/caregiver's involved: (This helps us to review files or ask precise questions)

Do you know where the incident occurred? (a classroom, playground, room, bus, car, bathroom, kitchen, field trip (where at) other)

Does this involve transportation? (Bus, car, van or school bus)

Is any child or children injured? What was the injury?

Do you have any pictures, audio or video that you wish to share ([OECOSLproviderinquiry@fssa.IN.gov](mailto:OECOSLproviderinquiry@fssa.IN.gov))

Have you or the program reported to Department of Child Services (800-555-5556)

Are there any other concerns you wish to add:

Complaint received by: (OECOSL name, extension number)	Date (month, day, year)	Time received
--	-------------------------	---------------

### OECOSL OFFICE ONLY BELOW

OECOSL assigned complaint number:	Assigned to:
-----------------------------------	--------------

Reviewed by:	Assigned to:
--------------	--------------

Date reviewed (month, day, year)	Date due (month, day, year)	Date received (month, day, year)
----------------------------------	-----------------------------	----------------------------------

