SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Fraud and Abuse Hotline Complaint/Allegation Form

Date:	Time:
Will you remain anonymous?**	❑ Yes ❑ No (If no, identify yourself below)
If no, do you want confidentiality?	❑ Yes (If yes, identify yourself below. We will not release your name without your consent, unless sexual harassment/workplace violence.) ❑ No
Are you willing to be interviewed?	❑ Yes ❑ No
Your Name:	Last Name: First Name: Middle Initial:
Mailing Address:	Street 1: Street 2: City: State: Zip Code:
Organization Name:	
Bureau/District Name/Location of Incident:	
Home Telephone:	( )
Work Telephone:	( )
E-Mail Address:	

Complaint Information (Who, What, When, Where, Why & How long)

Any witnesses? If yes, who?

Any tangible evidence? If so, keep in a secured location.

What other action have you taken regarding this complaint? If sexual harassment, must complete Office of Personnel Services Form.

Do you want someone to contact you on the results of this complaint?

**NOTE: Name is required for sexual harassment and workplace violence complaints. Also, name of accuser will be released to the alleged harasser at some point during the investigation. Anonymous claims cannot always be investigated.