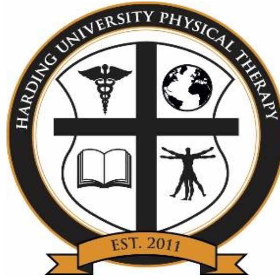

Complaint Form
Harding University Doctor of Physical Therapy Program

There is a strict policy against retaliation toward any person completing this form. Your concern will be forwarded to the Chairperson of the Department of Physical Therapy or his/her designee for handling. Details about the concern or the person completing this form will not be provided to third parties unless written consent is provided.

Receipt of your concern will be acknowledged within 3 business days.

Name: ___________________________________

E-mail Address: _________________________________

Street Address: ____

City/State/Zip: ____

Telephone: Home: _________ Work: ______________ Cell: _________________

In the space below, please state in detail your complaint. You may use additional pages if necessary.

In the space below, please state in detail what resolution or relief you are seeking. You may use additional pages if necessary.