COMPLAINT FORM

Name of Complainant:

_____

(Last) (First)

*Address:

_____

(Street)

_____

(City) (State) (Zip)

Home Phone ( ) _____ Business Phone ( ) _____

*Note: The information contained in this box will remain confidential.

Name of Person who Complaint is against:

_____

(Last) (First) (MI)

Address (may be employment):

_____

(Street)

_____

(City) (State) (Zip)

County Office of Education:_____

Employing School District Name:_____

Employing School: _____

Position & Title:_____

IT IS ESSENTIAL THAT YOU RETURN THIS FORM TO:

California Commission on Teacher Credentialing
Division of Professional Practices
1900 Capitol Avenue
Sacramento, CA 95811
Dominick Conde (916) 324-5678

AFFIDAVIT of: _____

I, _____ declare I have personal knowledge of the acts of misconduct by _____.

I certify under penalty of perjury of the laws of California that I have read the foregoing statement of facts and its contents, and that it is true and correct.

DATE:_____ _____

SIGNATURE OF COMPLAINANT