

COMPLAINT FORM

Name of Complainant:

(Last) (First)

*Address:		

(Street)		

(City)	(State)	(Zip)
Home Phone () _____		Business Phone () _____
Email Address _____		
*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
651 Bannon Street, Suite 602
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