



**Complaint Referral Form  
Medical Assistant Program**

5500 South Zapata Highway, Laredo, TX 78046

Phone: 956-721-5261 Fax: 956-721-5431

Email: [ma@laredo.edu](mailto:ma@laredo.edu)

**Complaint Against**

Name: \_\_\_\_\_

MA Program     Program Faculty     MA Student     MA Graduate

**Person Filing Complaint (\*Required)**

Name: \_\_\_\_\_

Physician     Clinical Instructor     Employer     Patient     Patient Family Member  
 Other

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Detail of Complaint**

Signature \_\_\_\_\_

Date: \_\_\_\_\_

The completed form can be emailed or mailed to the address listed at the top.

**\*Neither the Board nor any College employee shall unlawfully retaliate against any member of the general public for bringing a concern or complaint.**