

**CIVILIAN COMPLAINT OF EMPLOYEE MISCONDUCT**

(Form # EB17-004)

This form should be used exclusively to report employee misconduct. Complaints regarding California Department of Insurance Enforcement Branch policies and procedures should be discussed with the Captain at your nearest Regional Office. Upon completion of this form, you may either return it in person to the nearest Regional Office, or mail the form to the California Department of Insurance Enforcement Branch, Professional Standards Unit, 2400 Del Paso Road, Suite 250, Sacramento, CA 95834. A pre-addressed business reply envelope has been provided for your convenience. The form can also be emailed to [PSU@insurance.ca.gov](mailto:PSU@insurance.ca.gov). Please make a copy of the form for your records.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Date of Occurrence \_\_\_\_\_ Time of Occurrence \_\_\_\_\_

Location of Occurrence \_\_\_\_\_

Name, Badge Number(s) of Employee(s) involved (if known).

Name, address(es), and telephone number(s) of witness(es) present at time of occurrence (if known).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(LIST ADDITIONAL EMPLOYEES AND/OR WITNESSES UNDER THE "DETAILS" SECTION.)

Details - Please state your complaint, including names, times, locations, witnesses, and any other information that would help in investigating your complaint. If employee names are unknown, explain what each employee looked like. Please use additional pages if needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

**DEPARTMENT USE ONLY**

To be completed by the supervisor receiving this form.

Supervisor's name \_\_\_\_\_ Badge number \_\_\_\_\_

Date and time received \_\_\_\_\_

Final disposition \_\_\_\_\_

PSU tracking number assigned \_\_\_\_\_