**THIRD PARTY EXAMINER – COMPANY COMPLAINT**

Wisconsin Department of Transportation

MV3567 9/2019 Ch. 343 Wis. Stats.

Complete this form only if the issue still remains AFTER you have tried working with the Third Party Examiner. Submit this completed form to the address below. *(Attach any evidence that supports this complaint)*

Wisconsin Department of Transportation

Division of Motor Vehicles

CDL 3rd Party Audit Program

P.O. Box 7920

Madison, WI 53707-7920

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Your Name (Name of Person Filing the Complaint) | | | | Name of Examiner Your Complaint is Against | | | |
| Address | | | | Address | | | |
| City | State | Zip Code | County | City | State | Zip Code | County |
| (Area Code) Telephone Number | | Hours you may be reached | | (Area Code) Telephone Number – Work | | | |
| Email Address | | | | 3rd Party Tester/Company Name | | | |
| Incident Date | | | | Witness Name | | | |
| What is the issue? Answer the questions what, when, where, and who. *(Attach a separate sheet if additional space is needed)* | | | | | | | |
| Has any action been done to address this issue to date with the examiner? Be Specific. *(What measures were taken to resolve conflict)* | | | | | | | |
| What outcome do you seek? | | | | | | | |

I certify that the information on this form is the truth, as I perceive it, and that all witnesses are aware that they are mentioned in the complaint. **Return this completed form to the address listed above within 10 business days.**

Signature of Person Filing the Complaint Date (m/d/yyyy)