alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

WHISTLEBLOWER REPORTING FORM

Please include your name and contact information if we can contact you as part of the investigation.

Name (Optional)	**Address (Optional)**	**Phone (Optional)**
Agency, program or individual you are reporting about	**Address (If known)**	**Phone (If known)**

Briefly describe the improper activity(s) and how you know about them. Specify who, what, when, where, and how. Number the allegations. Use Additional paper if necessary.

Briefly describe the information that witness(s) will be able to confirm. Use Additional paper if necessary

Please list all documents or other items of evidence that prove the allegations to be true and explain how each item provides proof. Use additional paper if necessary. If you have any of the listed documents in your possession. Please provide copies.

Your complaint will be processed under the California Whistleblower Protection Act (California Government Code Section 8547, et seq.)This law empowers Alameda County Behavioral Health Care Services to investigate complaints of improper governmental activities but not to act as an advocate for individuals in their disputes with state departments or employees. By law, we must conduct out investigations confidentially, and therefore cannot keep you informed about our review of your complaint or the progress of any investigation that may follow.

Signature (Optional)	Date

Please mark as "*Confidential*" and send to:

Quality Assurance Office, 2000 Embarcadero Cove #400, Oakland, CA 94606
Fax: 510-639-1346 Email: ProgIntegrity@acgov.org