Supreme Court of the State of New York
Appellate Division: Second Judicial Department

GRIEVANCE COMMITTEE COMPLAINT FORM

Date:_____

COMPLAINANT INFORMATION

Your Name: (Mr.)( ) (Ms.)( ) _____
(Last) (First) (Initial)

Address: _____
(Street) (Apt. #)

_____
(City) (County) (State) (Zip Code)

Telephone: (Home) _____ (Office) _____

ATTORNEY COMPLAINED OF:

Name: _____
(Last) (First) (Initial)

Office Address: _____
(Street)

_____
(City) (County) (State) (Zip Code)

Telephone: _____

CONTACT WITH OTHER AGENCIES

Have you contacted any other agency, such as a Bar Association or District Attorney's Office, concerning this matter? _____

If so, state the name of the agency: _____

What action was taken by the agency? _____

COURT ACTION TAKEN BY YOU AGAINST THE ATTORNEY

Have you taken any civil or criminal action against the attorney? _____

If so, please name the court and provide the index number: _____

What action was taken by the court? _____

ALLEGATIONS

Explain your complaint against the attorney in as much detail as possible. When did you retain the attorney? How much did you pay? What legal services did the attorney agree to perform for you? What did the attorney actually do for you? What conduct did the attorney commit that you believe is improper? Send this office COPIES of all documents that you believe support your claim, with the names and addresses of any witnesses. (Please use a pen with black ink. If necessary, continue your narrative on a separate sheet of paper.)

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Please Sign Here

Note: Unsigned complaints and those sent by e-mail or fax transmission will not be processed.