COMPLAINT REPORT

Instructions:
Please fill out, date, and sign this report and submit it to the receptionist, Medical Director, or a Board member. A member of the staff will assist you in completing this form in a private setting, if you request. Written complaints may also be submitted by email or letter, if you prefer. You will be provided with an initial response within ten (10) working days of the date your written complaint is received.

Name of Patient:_____ Date: _____

Name of person filling the grievance/complaint:_____

Relationship: [ ] Self [ ] Family Member [ ] Advocate [ ] Other

Date the incident occurred: _____ Time: _____

Describe the nature of the complaint (be specific). Use reverse side of this form if additional space is needed.

_____

_____

If other persons involved, name them:

Name	Employee	Patient	Visitor
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]

If there were witnesses, name them:

Name	Employee	Patient	Visitor
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]

What actions or recommendations do you feel need to be taken?

_____

_____

_____ _____
Signature (person filing complaint) Date

For Office Use Only: Date Received: _____ Received By: _____

Attach supportive documents to this report, if appropriate. Use the back for any additional information or comments.