COMPLAINT/GRIEVANCE FORM

Patient Information

Patient Name:____

Local Address:____

Telephone #:____________________ **Date of Birth:**________________________

Complainant Information:

Name of Person Initiating Complaint:__________________________________

Address:____

Telephone #:____________________ **Relationship to Patient:**____________________

Nature of Complaint

☐ Appointment/Access ☐ Medical Care ☐ Problem w/Staff ☐ Policy/Procedure ☐ Medical Refill
☐ Billing ☐ Laboratory ☐ X-Ray ☐ Problem with MD/PA ☐ Referral
☐ Other:

Time & Date of Incident:______________________________

Names of Staff/or Witnesses Involved (if known):____________________________________

In your own words please tell us why you are not happy with the care or service you received:

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(Please continue on a separate sheet if necessary)

As a result of your complaint, what would you like to see happen?____________________________

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I understand that staff investigating this complaint may need to see and review health records, but that all information will be kept confidential. I further understand that this complaint/grievance will in no way affect any care provided.

Signature:____________________________ **Date:**________________________

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days. Please return this form to: Health Director, KTHC.