

Facility Complaint Form

Contact Information

Providing information about you will allow Department staff to contact you should additional information be needed. It is our policy to keep your name confidential. It may be necessary to share the nature of your complaint or the patient's name with the facility. Please do not attach **any additional** information, such as medical records, as it will not affect the outcome of the decision.

First Name

Last Name

Date:

Month

Day

Year

Please provide your contact information for the Department:

Address

City

State

Zip

Daytime Phone

Alternative Phone

Email Address

How are you related to the patient?

Do you wish to remain anonymous? Yes No

Patient Information

First Name

Last Name

Date of Admission:

Month

Day

Year

Date of Discharge, if applicable:

Month

Day

Year

Facility Information

Facility Name

Facility Address

Complaint Information

Have you filed a complaint with the facility?

Yes No

