PUREVIEW Health Center

PATIENT COMPLAINT FORM

Please fill out as many questions as possible:

Date: _____

Time: _____

Specific staff member? *(Click one)* Yes ◯ No ◯

Staff name: _____

Nature of Complaint:

Would you like to be notified of the resolution? *(Click one)* Yes ◯ No ◯

If yes, please give us your name and phone number:

For staff use only:

Staff member responding: _____

Chief Executive Officer's initials: _____

Staff recommendation for follow-up:

Follow-up complete: _____
(Date)

Received by Safety Committee: _____
(Date)