Ashland Health Center
"Your Community Health Center"

GRIEVENCE FORM

Date of Occurrence _____

Patient Name: _____

Address _____ City _____ State _____ ZIP Code _____

Daytime Telephone _____ Cell _____

Date of Birth _____ Sex _____

Status of Patient (Discharged) _____ Still in Facility (Room #) _____

Expired _____ (date and location) _____

Complainant Name (if not the patient) _____ Phone Number _____

Address _____ City _____ State _____ ZIP Code _____

Briefly describe what actually occurred. Limit comments to the facts. Identify dates, names, places, times, facility, and location(s) (essentially, who was involved, what happened, when did it occur, where did it occur, and how did it occur). Describe any physical harm incurred by the patient. Use the form fields to complete the information.

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_____ _____

Signature of the person completing this form Date

_____ _____

Recipient of form Date

Please leave in the complaint lock box at the Acute or SLU nurses Station or with the Hospital/Clinic Receptionist