ASHLAND HEALTH CENTER

GRIEVANCE FORM

Patient Name:		Date of Occurrence:	
Address:	City:	State:	ZIP Code:
Date of Birth:	Sex: ☐ Male ☐ Female		
Daytime Telephone:	Cell Phone:		
Status of Patient (Discharged):	Still in Facility (Room Number):		
Expired: ☐ Yes ☐ No	Date and Location:		
Compliant Name (if not the patient):		Phone Number:	
Address:	City:	State:	ZIP Code:

STATEMENT/COMPLAINT

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.

Signature of person completing this form:	Date:
Recipient of Form:	Date:

Please submit the completed form to Human Resources or with the Hospital/Clinic Receptionist.