Crescent Community
HEALTH CENTER

PATIENT COMPLAINT AND GRIEVANCE FORM

Patient Name:_____ **Telephone #:**_____

Address: _____

Person Reporting: _____

If other than patient above:

Relationship to patient: _____**Telephone #:**_____

Address: _____

Date Received: _____ **Time Received:** _____ **Received By**_____

Report Received: _____**In Person** _____ **Telephone** _____ **Mail (please attach)**

Specifics of Report:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Summary of investigation:

Response

Respondent: _____ **Date:** _____ **Time:** _____

Method of Response: _____**In Person** _____ **Telephone** _____**Mail**

Detail of Response: (Attach if Written)