Crescent Community
HEALTH CENTER

Patient Complaint and Grievance Form

Patient Name: _____

Phone Number: _____

Address: _____

Email: _____

Person Reporting: _____

If other than patient, relationship to patient: _____

If other than patient, person reporting's phone, address and email: _____

_____

Date submitted: _____

Describe the incident or complaint. *Please include as much detail, including names of those involved, date and time the incident occurred, location, and names of any witnesses. Use the back or additional pages, if necessary.*

How would you like to be contacted to receive a response? _____

You may return this form:

1. In person to any CCHC staff member
2. By mail it to: CCHC, Attn: Director of Patient Experience, 1690 Elm Street, Suite 300, Dubuque, IA 52001
3. By phone at 563.690.2424
4. By email to concerns@crescentchc.org