PATIENT COMPLAINT/GRIEVANCE FORM

Patient Name: _____ DOB: _____

NATURE OF COMPLAINT/GRIEVANCE:
Please describe the nature of your complaint or grievance in detail.

_____
_____
_____

DATE OF INCIDENT: _____ **LOCATION OF INCIDENT:** _____

NAMES OF INDIVIDUALS INVOLVED: _____

RESOLUTION DESIRED:
Please describe the outcome or resolution you are seeking:

_____
_____
_____

I acknowledge that as a patient of CBSC Clinic, I have the right to voice my concerns and file a complaint or grievance without fear of reprisal. I also understand that it is my responsibility to provide accurate and detailed information regarding my complaint or grievance. By signing this form, I am formally submitting a complaint or grievance to CBS Clinic. I acknowledge that the clinic staff will review and address my concerns in a timely manner.

Signature: _____ Date: _____

Witness Signature (if applicable): _____ Date: _____

Note: We take patient complaints and grievances seriously and are committed to addressing them promptly and effectively. Your feedback is valuable to us and helps us improve our services.

CLINIC STAFF RESPONSE – FOR CLINIC USE ONLY

DATE RECEIVED: _____ **DATE ACKNOWLEDGED:** _____

INVESTIGATION OUTCOME:

_____
_____
_____

RESOLUTION PLAN:

_____
_____
_____

Clinic Staff Representative Signature _____ Date: _____

KEEP FOR YOUR RECORDS