Patient Comment/Concern Form

Please take a moment to fill out this form as completely and honestly as possible to ensure that we may provide you the best possible care. We appreciate your honesty and hope to remedy the situation.

1. Patient Information

Last Name, First Name	Date of Birth	Telephone	Today's Date

If the person filling out this form is different than the patient above:

Last Name, First Name	Relationship to patient	Telephone

2. Patient Comment/Concern

In the space provided below, please write a detailed account of the experience with use of names and dates if possible. If more space is needed, please write on another page and attach it to this form.

3. Comment/Concern Record (*This Section for Official Use Only*)

Report Submitted: ☐ In Person ☐ Via Telephone ☐ Via Mail Date Received: _____ Received By: _____

Date Given to Dept. Director	Date of Dept. Director's Response/Action Taken	Date of Program Director's Response, if needed

4. Comment/Concern Response (*This Section for Official Use Only*)

Response Submitted: ☐ In Person ☐ Via Telephone ☐ Via Mail Date & Time: _____ Respondent:_____

In the space provided below, please write a detailed account of the response. If written on another page, please attach to this form.