Grievance Form

Initial concern received Date: _____ Time: _____ Date of Occurrence: _____ Time: _____

Report initiated by:

Name/title: _____

Department: _____

Phone: _____ Date: _____ Time: _____

Referred to (Director/Manager of Department Affected):
Note: Send the original of this form to the person listed here; do not send the form to more than one person.

Name/title: _____

Department: _____

Phone: _____ Date: _____ Time: _____

Name of person(s) registering concern:_____

☐ Patient ☐ Family Member ☐ Visitor Specific Dept:_____ Room #_____Admit Date: _____

Medical Record #_____

Phone Number to contact customer: Home (___)_____Cell (___)_____ Work (___)_____

Customer Address_____

(Attach registration face sheet when available)

Statement of Problem: _____

_____

_____

_____

Investigation of Concern: Name of Reviewer: _____ Date Initiated_____

_____

_____

_____

(If unable to resolve clearly state reasons) Customer to be contacted within 5 business days

Resolution of Concern: Customer Contacted Date: _____Time: _____ Date: _____ Time: _____

_____

_____

_____

Customer Satisfied Y____ N ____
Resolution Letter Date Sent_____

Risk Hold on Billing Required Y____ N____

Date Initiated _____

PCR Initiated Y____ N____

Forward Completed Form To Risk

Date Sent _____