

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 _____
