PATIENT GRIEVANCE REPORT

To our patients: prior to completing this form, please make every effort to communicate your concerns to the staff, supervisor, and management involved for immediate resolution. Please be assured that if you are unable to do so, you may make a formal complaint (or Grievance). Either event will not affect your care or treatment. All matters will be handled in a confidential manner. If you choose to report a Grievance, you will be contacted within twenty-four **(24) hours** (or next business day) to acknowledge receipt of your Grievance. You will receive a **written response** regarding our findings and resolution within **seven (7) days minimum and thirty (30) days maximum.** This is part of your Patient Rights and fully supported by this Facility.

Date of the Report:

Patient Name:

Date/Time of the Occurrence or Concern:

Place of the Occurrence or Concern:

Description of your concerns; events; individuals involved:

Which "PATIENT RIGHT" is of concern to you?

What would resolve this issue for you?

X_____