CUSTOMER COMPLAINT FORM

CLIENT/PATIENT NAME/ADDRESS: **Date:**_____

_____

_____

_____

Phone Number: _____

Email Address:_____

DATE OF INCIDENT:_____

LOCATION OF INCIDENT:_____

NAME OF EMPLOYEE/CONTRACTED AGENT AGAINST WHICH THE COMPLAINT IS FILED:_____

DESCRIPTION OF COMPLAINT:_____

_____

_____

_____

_____

_____

SIGNED: _____**DATE:** _____

ACTION TAKEN:_____

_____

_____

_____

_____

ACTION TAKEN BY: _____**DATE**_____

FOLLOW UP/REFERRAL:

_____

_____

_____

_____

FURTHER REVIEW NEEDED: ____**YES** ____**NO**

1. **PATIENT/CLIENT SATISFACTION:** _____**YES** _____**NO**
2. **INCIDENT REPORT COMPLETED:** _____**YES** _____**NO**

PUBLIC HEALTH DIRECTOR'S SIGNATURE:_____

DATE:_____

Created 5/2024