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**PATIENT GRIEVANCE/COMPLAINT FORM**

We understand that conflicts and concerns can arise during a patient visit. Parkview Hospital recognizes your right as a patient or family member to file a complaint concerning care or services received at Parkview Hospital. If you or a family member has a grievance or complaint that you feel has not been resolved, we encourage you to let us know. The filing of a grievance will not adversely affect current or future patient care. You may file the complaint directly to the **Hospital Administrator** or **Any Hospital Employee** and a representative of the Patient Concerns Committee will contact you about the grievance.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Contact #: \_\_\_\_\_\_\_\_\_\_\_

Tell us the nature of your grievance or complaint (please include dates and times when possible): \_\_\_\_\_\_\_\_

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**(If additional space is needed, continue on the back of this form)**

How would you like to see this issue resolved? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of patient/person making complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All** complaints are reviewed by the Patient Concerns Committee. Every effort is made to investigate and respond to complaints in a timely manner.