PATIENT COMPLAINT AND GRIEVANCE FORM (PCGF)

Patient Name: _____

Clinic Location: Columbus Consolidated Government Health and Wellness Center

Preferred Contact Telephone #: _____

Email Address: _____

Date of incident: _____

Please describe the complaint and grievance, including dates, times, complete names of others involved, etc.:

_____

_____

_____

_____

Resolution sought: _____

_____

_____

_____

_____

_____

Patient Signature: _____

CareATC Internal Use Only:

Date Received: _____ Received Via: ☑ Email ☑ In Person

Corporate Complaint Form Completed / Date: _____

Comments: _____

_____

_____

Staff Employee Signature: _____

Please leave this form at the HWC or send via email to the CareATC Clinic Manager, Attention: Sheria Sells at ssells@careatc.com