

Patient Grievance Form

Mail the completed, *signed* form to: Sunshine Community Health Center

Risk Management Department

HC 89 Box 8190

Talkeetna, AK 99676

OR drop this form off at: Sunshine Community Health Center

Willow or Talkeetna Office

Name of Person Completing this Form:	
Date Form Completed:	Relationship to Patient:
Patient Name:	Date of Birth:
Address:	
Telephone Number:	Cell Phone:
Name of Provider:	Location Frequented:
Please describe your grievance in de (please attach any additional documentation)	etail including dates/names:

Type of grievance (Check all that apply) Staff Factors **Patient Care Factors Organizational Factors Medical Staff** __Courtesy __Waiting Times Quality of Care __Quality of Care __Timeliness of Care __Communication __Timeliness of Care __Cleanliness __Billing, charges __Accessibility Teaching Privacy __Other __Other Other __Other What action are you requesting? Thank you for your comments, an SCHC representative will contact you within 72 hours of receipt. For Clinic Staff Only Name / department of person initiating this record: _____ Risk Manager Referred to: _____ Manager/Supervisor _____ Executive Director Follow-Up Action taken: Supervisor Signature: Executive Director Signature: _____