

Complaint Form

The information MUST be completed to investigate your complaint.



COMPLAINANT INFORMATION

Name	Address	Contact Details

WHAT IS REASON FOR YOUR COMPLAINT? TICK APPROPRIATE

<ul style="list-style-type: none">– Quality of Care– Misdiagnosis– Customer Service– Work Cover– Billing	<ul style="list-style-type: none">– Abuse– Sexual contact– Misfiled prescription– Inappropriate prescribing– Excessive test/treatment	<ul style="list-style-type: none">– Patient abandonment/neglect– Impaired provider– Failure to release patient records– False advertising	<ul style="list-style-type: none">– Other, please explain....
--	---	--	---

DETAILS OF THE COMPLAINT

Provide a complete description of the complaint. Include facts, details, dates, locations, who, whom, when & where

--

Signature: _____ Date: _____
(Required to file complaint)

Thank you for your feedback. It is our policy to respond to your complaint/feedback within 7 business days.

1st page for complainant