Riverside-San Bernardino County Indian Health, Inc.
COMMENTS/COMPLAINTS REGARDING PROGRAM SERVICES

(For use by Patients)

CONFIDENTIAL - DO NOT PHOTOCOPY.

Date:_____ Clinic:_____ Department: _____

Patient's Name:_____ Phone #:_____

Patient's Address: __

Form Completed by: ❒Patient ❒Other *Name* _____ Relationship _____

Date of Incident:_____ Time of Incident: _____

Please describe the comment/complaint and include pertinent information (names, titles, of employee(s), etc.)

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Comments/Complaint form to be submitted within 30 days of concern/incident.

COMPLETED FORM TO BE SENT TO QUALITY MANAGEMENT
Quality Management Department is to respond to you within 2 days of receipt.

This form should not be copied or included as part of a patient's Medical Record.
QM form #08-001 (Rev. 01/2012)