PATIENT COMPLAINT FORM

We are here to help you. Please ask any staff member if you require assistance completing this form.

Date of Incident: _____ Time: _____ Today's Date: _____

Patient's Name: _____ Phone Number: _____

Address: _____ Zip Code: _____

Your Full Name: _____

Staff Member(s) Involved: _____

Clinic Location: ☐ Sheboygan ☐ Manitowoc

PATIENT DESCRIPTION OF EVENTS (Please use back of form, if necessary).

HOW WOULD YOU SUGGEST THAT WE SOLVE THIS PROBLEM?

Thank you very much for this information. Please give this completed form to any LCHC staff member. You may request a copy of this form for your records. Lakeshore Community Health Care will contact you by mail or phone.