Patient Complaint / Concern Form

Date of Complaint: _____

Time of Complaint: _____

Name of Person Making Complaint: _____

Name of Patient: _____

DOB: _____ Clinic: _____

Specific Complaint: ☐ Staff Behavior ☐ Quality of Care-NSG
☐ Quality of Care-Physician ☐ Time / Delays
☐ Other

Comments: _____

_____

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Signature _____ Date _____

Fax Form to: 918-779-7454

CareATC Office: 918-779-7402