PFC ASSOCIATES LLC
Police & Fire Clinic

PATIENT COMPLAINT FORM

It is important for us to know how we are doing and if there are areas for improvement.

DATE OF OCCURRENCE:_____

NAME_____ DEPARTMENT:_____

PHONE NUMBER:(_____)_____

DESCRIPTION OF COMPLAINT (use back of form if more space is needed): _____

_____

_____

_____

COMPLAINT PROCESS:

(1) Please complete the Patient Complaint Form;
(2) You will be contacted within (24) hours;
(3) The complaint will be investigated;and
(4) You will be contacted with the results of the investigation.

Note: Please notify a staff member if you would like to speak immediately to your department liaison, PFC Associates leadership, and/or Paul Quander, Director of Medical Services Division.

Thank you for your Comments

Patient Complaint Follow-Up to be Completed by PFC Only

_____

Investigation: _____

_____

_____

_____

_____

Corrective Action(s) Taken: _____

_____

_____

_____

_____

_____

Report Prepared by: _____ Date: _____

Report Reviewed by: _____ Date: _____

01/10