Print Form

Barren River
DISTRICT HEALTH DEPARTMENT

PATIENT COMPLAINT FORM
P-11

Name	County of Residence

Address	Phone Number

Please state the nature of your complaint in detail below. If additional space is needed, please use a separate sheet of paper.

Give the name(s) below of staff that you believe treated you inappropriately. If more than three, please use a separate sheet of paper.

Name Name Name

Please select the actual date, and time if known, that the alleged incident occurred.

Complaintant Signature Date

Signature of Authorized Rep Date