



CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
"The Clinics With a Heart"

Complaint/Compliment and Follow-Up Form

Date of Occurrence: _____ Date Received: _____

Location of Occurrence: _____

Person Reporting/Receiving Complaint: _____

Complaint/Compliment From: _____ Patient _____ Family/Visitor _____ Staff /Provider _____ Other: _____

Name: _____ Phone #: _____ DOB: _____ MR: _____

Complaint/Compliment:

Signature: _____

.....

Department F/U: _____

Department/Manager Findings & Actions:

Signature: _____

*Attach a copy and any other relevant documents

*After completion by Department Manager, forward original to Risk Management