

### Patient Complaint/Grievance Form

Every patient should have reasonable expectations of care and services provided to him or her while at Battle Creek Health System. Battle Creek Health System is committed to addressing situations when those expectations are not met in a timely, reasonable, and consistent manner.

The Patient Relations Department is available to assist you with completing this form, filing a formal grievance over the phone, or to answer questions at (269) 966-8333. Please return this form to: **Battle Creek Health System, ATTN: Patient Relations Department, 300 North Avenue, Battle Creek, Michigan 49017.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(LAST) (FIRST) (MI)

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
(OPTIONAL)

#### **DETAILS OF YOUR COMPLAINT**

(Please be as specific as possible with the following [1] please state your concern; [2] date of event; [3] time of event; [4] staff member(s) involved, and [5] location of event. Use the other side of this form if you need more room.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_  
Signature of Patient or Legal Representative

If Legal Representative, state relationship: \_\_\_\_\_

#### **THIS SECTION TO BE COMPLETED BY THE REVIEWER**

Date Received: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Reviewer's Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action taken: \_\_\_\_\_

Date Patient was notified of resolution by mail to address stated above: \_\_\_\_\_

Date: \_\_\_\_\_ Healthcare Representative Signature \_\_\_\_\_