PERMIACARE

PATIENT COMPLAINT FORM

Date :

Person Registering the Complaint:

First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	

Patient Information (if other than the person registering the complaint)

First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	

DETAILS OF THE COMPLAINT

Provide Details of your concern including the following as appropriate/applicable

Date of Incident:	Time of Incident:
Was this a CLINIC visit: O YES O NO	Was this a PROGRAM visit: O YES O NO
Name of the Healthcare team member(s) involved	
Doctor:	Nurse:
Receptionist:	Other:
Other:	Other:
What is your complaint/concern: (continued on reverse)	

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Describe any efforts you have made to resolve this matter:

Please describe the result or outcome that you seek:

Do you consider this matter urgent O YES O NO
If yes, please explain why:

Please forward the completed form to

Susan Halydier
Client Rights Advocate
401 E. Illinois
Midland, TX 79701

EMAIL:
shalydier@permiacare.org
FAX: 432-570-3346

FOR OFFICE USE ONLY	
Complaint received by	Date
Compliant Investigated By	Date
Date response sent to client	Resolved O YES O NO