**Complaint/Grievance/Appeal Form**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |
| Name | |  | | | | | |
| Address | |  | | | | | |
| Contact number | |  | | | | | |
| Date/Time | |  | | | | | |
| Is this a: |  | | Complaint |  | Grievance |  | Appeal |
| Describe in detail the nature of your complaint/grievance/appeal. | | | | | | | |
| Who did you first report your complaint/grievance/appeal to? | | | | | | | |
| Describe how you feel your complaint/grievance/appeal can best be resolved. | | | | | | | |
| Describe what changes you feel should be made in order to avoid this issue in the future. | | | | | | | |
| Signature | |  | | | | | |
| Date/Time | |  | | | | | |
| Received by: | |  | | | | | |
| Date/Time | |  | | | | | |
| **Corporate Administrator notified Date/Time:**  **Acting Site Administrator notified Date/Time:**  **Clinical Director notified Date/Time:**  **Department notified Date/Time:**  **\*Notification must occur immediately (verbally) and within 48 hours (in writing) following receipt of complaint/grievance/appeal** | | | | | | | |