CALLEN LORDE
COMMUNITY HEALTH CENTER

PATIENT COMPLAINT FORM

356 West 18th Street
New York, New York 10011

212 271 7200 patient care
212 271 8111 fax

_____/_____/_____ _____ am/pm
Date Time

_____
Print Name of Patient with Complaint

Chart # _____

_____ (_____)_____-_____
Patient's Address & Telephone #

Please describe the complaint and include any pertinent information (names, titles, etc.):

(*Please attach additional pages as needed.*)

Patient's Signature: X_____ Date: _____/_____/_____
(If this form was written on behalf of the patient, please check here: □) *(If this complaint was taken via phone, please check here: □)*

Staff's Signature: X_____ Date: _____/_____/_____

Staff Print Name_____ Title _____

All complaints (anonymous or signed) will be given serious attention. Patients should not fear reprisal because of their complaints.

The ASSOCIATE EXECUTIVE DIRECTOR will receive and forward this form to the appropriate DEPARTMENT HEAD, who will directly address your concerns.

(2/06)