AIM Center
for Health and Wellness

promoting the health and well-being of our patients

Patient Complaint Form

Name of person making compliant: ____

(Please check one)

___ Patient ___ Patient's Family member ___ Vendor/ Marketer ___ Other

Address: ______________________________ City/State/Zip: _________________

Phone: _____________ Fax: ______________ Email: _____________________

Date of incident: _________________

Nature of complaint:

____
____
____
____
____

Results of investigation:

____
____
____
____
____

Action Taken:

____
____
____
____

Date complainant contacted with results of investigation: ___________

Complainant notified via: __ Telephone __ Letter __ Fax __ E-mail

Name of person taking complaint: ______________________ Date: ___________

Name of complaint investigator: ______________________ Date: ___________