ITHACA COLLEGE
Hammond Health Center

COMPLAINT/GRIEVANCE FORM

Patient Information

Patient Name:_____ **Student ID #:**_____

Local Address:_____

Telephone #:_____ **Date of Birth:**_____

Complainant Information:

Name of Person Initiating Complaint:_____

Address:_____

Telephone #:_____ **Relationship to Patient:**_____

Nature of Complaint

☐ Appointment/Access ☐ Medical Care ☐ Problem w/ Staff ☐ Policy/Procedure ☐ Medicine Refill

☐ Billing ☐ Laboratory ☐ X-Ray ☐ Problem with MD/PA ☐ Referral

☐ Other:_____

Time & Date of Incident:_____

Names of Staff Involved (if known):_____

In your own words please tell us why you are not happy with the care or service you received:

_____

_____

_____

_____

_____

(Please continue on a separate sheet if necessary)

As a result of your complaint, what would you like to see happen?_____

_____

I understand that staff investigating this complaint may need to see and review health records, but that all information will be kept confidential. I further understand that this complaint/grievance will in no way affect any care provided.

Signature: _____ **Date:** _____

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days. Please return this form to: Manager of Health Center Operations, Ithaca College, Hammond Health Center, 953 Danby Road, Ithaca, N.Y. 14850 OR Fax to: 607-274-1844