Web Compliment / Complaint FORM

TODAY'S DATE: ____

PREFERRED PRONOUN: ◯ HE ◯ SHE ◯ THEY ◯ ZE OTHER: ____

DO YOU WISH TO BE CONTACTED? ◯ YES ◯ NO FOLLOW UP REQUIRED

FIRST Name: ____ LAST Name: ____

PHONE (*Preferred*): ____________________________________EMAIL: ____

DATE OF INCIDENT: ____

FORM COMPLETED BY: ◯ Client / Resident ◯ Family Member ◯ Other

PROGRAM: ◯ Community Care ◯ Bethell Hospice Residential ◯ Spiritual/ Bereavement:

LEVEL OF SATISFACTION: ◯ Satisfied ◯ Dissatisfied ◯ Very Dissatisfied

Description of compliment/complaint: ***(Please include dates and the names of all individuals involved)***

Action Requested:

Please email the completed form to qualityimprovement@BethellHospice.org . Thank you.

Follow up / Conclusion: ***(Office use only)***

FORM PROCESSED BY (*Print*):____ DATE: ____

MANAGER'S SIGNATURE: ____ DATE: ____

EXECUTIVE DIRECTOR'S SIGNATURE: __________________________________DATE: ____