GULF COAST ENDOSCOPY CENTER OF VENICE

COMPLAINT / GRIEVANCE FORM

Patient Name:	Date of Birth:
Address:	Date of Event:
Email address:	Phone #:

Nature of Complaint / Grievance (use other side if more space is needed):_____

_____

_____

_____

_____

_____

Name of staff member(s) involved:_____

_____

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 investigations will be kept confidential. I further understand that this complaint will in no way affect any care provided.

_____ _____

Patient/Representative Signature Date

For Internal Use Only

Date Received:	Received By:
Investigated By:	Date Investigated:
Comments:	
Date Resolved/Pt Notified:	By: