



# Complaint Form

FOR OFFICE USE: Date Received: _____
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## Complaint Report

If you need assistance with completing this form, please contact the Quality and Compliance Manager at 541-447-2631 or toll free at 888-532-6247, TDD711.

## Contact Information

### Rimrock Patient Name:

FIRST	MIDDLE	LAST
BEST PHONE NUMBER: (So we can contact you if we have questions):		(     ) _____ - _____

### If You Are Not the Patient, Your Name (person initiating complaint):

FIRST	MIDDLE	LAST
Your Relationship to Rimrock Patient:		
BEST PHONE NUMBER: (So we can contact you if we have questions):		(     ) _____ - _____

## Complaint Information

Is your complaint regarding a denial of services or benefits?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Does this complaint involve an urgent situation that cannot wait?	<input type="checkbox"/> YES*	<input type="checkbox"/> NO	

If YES\*, state the reason that it is urgent:

### Tell Us About Your Complaint (Attach additional information and notes as needed):

What Happened?						
When Did It Happen?	MONTH:	DAY:	YEAR:	TIME: ____:____	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
When did you first make someone aware of this complaint?	MONTH:	DAY:	YEAR:	ADDITIONAL INFORMATION, IF NEEDED:		
Who did you first make aware of this complaint?	FIRST		LAST		ADDITIONAL INFORMATION, IF NEEDED:	
What staff, if any, or others were involved?	FIRST			LAST		
	FIRST			LAST		
	FIRST			LAST		
	FIRST			LAST		
Any Additional Information You Want Us to Know?						