SCSU MEDICAL CLINIC & COUNSELING AND PSYCHOLOGICAL SERVICES
COMPLAINT FORM

Date & time complaint received: _____

Name of complainant: _____
Address: _____
Phone: _____
Insurance: _____
Student ID: _____

Name of person completing complaint form (if staff): _____

Describe nature or circumstances pertaining to the complaint:

Complainant or staff signature _____ Date _____

Describe what has been done to resolve/attempt to resolve this situation and the outcome:

Complainant or staff signature _____ Date_____

Please have a member of SCSU Medical Clinic or Counseling and Psychological Services staff contact the complainant regarding this complaint. ☐ Yes ☐ No

For office use only:
Medical or counseling director review:

Signature _____ Date _____

Management review:

Signature _____ Date _____