

**STUDENT HEALTH 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 SHS staff contact the complainant regarding this complaint. Yes No

For office use only:

Medical director review:

Signature _____

Date _____

Management review:

Signature _____

Date _____