

**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 \_\_\_\_\_