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| C:\Users\chill\Downloads\revised ame logo2.png | Form Identification: 600-88MDC Version: 1.00 Last Revision: | **Patient Complaint Form** |
| Next Review: April 2019  Contact Officer: V.P. of Accessibility Medical | Approved By: C.E.O.  Date: |

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| Date Reported: | |  | Person completing this form: | | | |  | |
| Patient Name:  Patient Address:  Patient Phone:  HICN: | |  | | |  | |  | |
| Person filing Complaint: | |  | | Relationship to Patient: | | |  | |
| Contact Phone Number: | |  | | | | | | |
| Summary of the Complaint: | | | | | | | | |
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| Reviewed by: | | | | | | | | |
| Recommendations for action: | | | | | | | | |
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| Actions:(please note all actions and conversations, along with dates) | | | | | | | | |
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| Final Resolution: | | | | | | | | |
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| Response to Customer: (Written within 14 days when unresolved)  Verbal  Written (attach copy) | | | | | | | | |
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| Management Signature: |  | | | | | Date: | |  |

**Document History & Version Control**

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| **Version** | **Date Approved** | **Approved By** | **Brief Description** |
| 1.0 |  | C.E.O. | Establishment of Patient Complaint Form |