Springfield Hospital

Where People Come First

Complaint/Grievance Form

Patient Information

Patient Name: ____

Local Address: ____

Telephone Number: ___________________________ **Date of Birth:** __________________________

Best day/time to be reached: ____

Complainant Information

Name of Person Initiating Complaint: ____

Address: ____

Telephone Number: ________________________ **Relationship to Patient:** ___________________

Nature of Complaint

☐ Appointment/Access	☐ Medical Care	☐ Problem w/staff	☐ Policy/Procedure	☐ Medication
☐ Billing	☐ Laboratory	☐ X-Ray	☐ Problem with MD, NP, PA	☐ Referral

☐ Other____

Time & Date of Incident: ____

Names of Staff Involved (If known):____

In your own words please tells us why you are not happy with the care or service you received:

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(Please continue on a separate sheet if necessary)

As a result of your complaint, what would you like to see happen? ______________________________

____

I understand that staff investigating this complaint may need to see and review health records, but that all information will be kept confidential. I further understand that this complaint/grievance will in no way affect any care provided.

Signature: ____ **Date:** __________________________

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days. Please return this form to Connie Smith, Executive Assistant to the CEO, Springfield Medical Care Systems, 25 Ridgewood Road, Springfield, VT 05156