Willamette UROLOGY

Patient Complaint Form

Willamette Urology is committed to providing our patients the best level of care possible. Please complete this form if you have concerns about the care or treatment that you or a family member are receiving or did not receive. We will investigate your concerns based on the information that you provide. After review, one of our representatives may contact you for additional information. We will respond to your complaint after the investigation is complete. Please return this form to: Willamette Urology, ATTN: Bryce Carman, 2973 12th St. SE, Salem, OR 97302.

Patient Name: _____ Date:_____
(Last) (First) (MI)

Address: _____

Telephone: _____

Date of Birth: _____

DETAILS OF YOUR COMPLAINT

(Please be specific as possible with the following: (1) please state your concern; (2) date of event; (3) time of event; (4) staff member(s) involved, and (5) location of event. Please use the other side of this form if you need more room.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Patient or Representative Date

If representative, state name and relationship: _____

THIS SECTION TO BE COMPLETED BY THE REVIEWER

Date Received: _____ Reviewed by: _____

Date patient or representative was notified by mail to address stated above: _____

Healthcare Representative Signature: _____ Date: _____