



Lake Health District

# Complaint / Compliment Grievance Form

Revised 07/2023

Lake Health District  
Lake District Hospital, Lake Health Clinic,  
Lake Health Specialty Clinic,  
Lake District Emergency Medical Services  
Lake County Public Health, Lake District Behavioral Health

This form may be used to file a complaint, compliment, or grievance with Lake Health District regarding care provided by medical practitioners, clinical staff, and/or other Lake Health District Staff.

*You may also be file without using this form by submitting a detailed written letter, email ([CRM@LakeHealthDistrict.org](mailto:CRM@LakeHealthDistrict.org)), or by calling 541-947-7298.*

If you choose to use this Complaint Form, please complete the following information. Please attach any photocopies of documents, including medical records if available, that are pertinent to your complaint. State in detail all the facts which you believe justify your complaint. Use additional paper as necessary.

**1) Name of Reporter (Your Name):**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**2) Name of Patient (if not complainant above):**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**3) Event Type:**

☐ Complaint ☐ Compliment ☐ Grievance:

**4) Complaint Against:**

☐ Provider MD/DO ☐ Nurse Practitioner ☐ Physician's Assistant ☐ Clinical Personnel ☐ Other Staff

Name - First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
License Number (if known): \_\_\_\_\_ Phone: \_\_\_\_\_

**5) Specific Information about your Complaint:**

When did the event occur? \_\_\_\_\_ Location/Department: \_\_\_\_\_

Do you feel another department is involved with or needs notification of this event?

☐ Yes ☐ No If so, where: \_\_\_\_\_

Describe the event: (facts only please)

Expectations:

☐ Don't want to happen to anyone else ☐ Apology ☐ Better Communication

☐ Billing Adjustment ☐ Compensation: \_\_\_\_\_ ☐ Face to face with: \_\_\_\_\_

☐ Notification to: \_\_\_\_\_ ☐ Talk with administration

☐ Other: \_\_\_\_\_

Witnesses:

I certify that everything in this statement is true and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Confidential Information:** Quality Assurance Process. This is for internal use only and should not be construed as a notice to parties outside of Lake Health District or its affiliated entities.