Islands Community Medical Services
15 Medical Center Loop
Vinalhaven, Maine 04863
ATTN: Executive Director
Phone: 207.863.4109 Fax: 207.863.2737

PATIENT COMPLAINT/GRIEVANCE FORM

Patient Information:

Patient Name: ____ Date of Report:__________________________

Local Address: ____ Phone Number: _______________________

Date of Birth: ______________________________________

Complainant Information:

Name of person filling out form if other than patient: ____

Mailing Address: ____

Phone Number: _________________________________ Relationship to Patient: ____________________

Time & Date of Incident: ____________________Name of Staff Involved (if known):______________________________

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

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 10 days. Please complete and submit this form by either mailing, hand delivering, or faxing to ICMS.

-- **Office Use Only** --

Date complaint received: __________________________ Received by: ________________________________

Reviewed by: ___________________________________

Notes: