TSÉHOOTSOOÍ NAHATA'DZIIL NIHI DINE'É BÁ
Medical Center Health Center Wellness Center
Facilities of Fort Defiance Indian Hospital Board, Inc.

PATIENT COMPLAINT/GRIEVANCE FORM

All information will be kept confidential

Patient Name:	**Patient Chart No. or Date of Birth:**
Patient Address (P. O. Box or Street, City, State, Zip Code):	**Patient Phone No.:**

If someone other than the patient is completing this form, please fill out the information below

Name:	**Relation to Patient:**
Address (P. O. Box or Street, City, State, Zip Code):	**Phone No.:**

Department Involved:	**Employee Name:**
Date of Incident:	**Time of Incident:**

Describe your concerns in detail with names, titles, department, dates, times, etc. Use back of sheet if necessary.

Signature of Patient **Date** **Signature of Patient Representative** **(if applicable)** **Date**

For Patient Relations Department Only:

Date/Time Received: _____@_____ Received by: _____

Title: _____ Department: _____

Please return form to the Patient Advocate ▪ P.O. Box 649 ▪ Fort Defiance, AZ 86504 ▪ (928) 729-8113