SONOMA COUNTY INDIAN HEALTH PROJECT
144 Stony Point Road
Santa Rosa, CA 95401

☐ Formal Grievance
☐ Informal Grievance

Confidential and Sensitive. This is intended for internal use **ONLY** .

PATIENT GRIEVANCE FORM

Patient Information (please print)	Grievance Information
Name: Address: Phone:	Date of Occurrence: Time and Location: Name(s) of Witness(es) present:

- Please explain in your own words, what happened and why you are filing a grievance: *(For more space, please use the back of the form.)*

- What action do you believe should be taken as a result of you filing this grievance?

- May we contact you by phone, if we have any further questions about your grievance? ☐ Yes ☐ No

Signature:_____ Date:_____

Do not write below this line – SCIHP personnel only

☐ Grievance by phone	☐ Grievance in person		☐ Grievance by mail		☐ Other:		
Date grievance Rec'd:		Pt. Services Coordinator (Signature):					
Forwarded to:		Department:		Date:			
Forwarded to:		Department:		Date:			
Date of receipt letter to patient (attached):							