



NEHALEM BAY
HEALTH CENTER & PHARMACY
 COMPASSIONATE COMMUNITY CARE

Please place your completed form in the secure Patient Feedback box near the front desk or email directly to the Nehalem Bay Health Center & Pharmacy at feedback@nehalemhealth.org.

230 Rowe Street | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | nehalemhealth.org

Patient/Customer Grievance Form

Patient/Customer Name: _____ Telephone #: _____

Address: _____

Person Reporting: _____

If other than patient/customer:

Relationship to patient/customer: _____ Telephone #: _____

Address: _____

Please provide detailed information regarding your complaint. It will help us to know names, dates, times and who was involved with your concerns and anything else you feel would be important for us to know:

Do you want this complaint to be shared with the staff member(s) involved in this complaint?

YES – It is okay for you to share my identity with the staff member(s) mentioned on this form.

NO – I prefer to remain anonymous and do not want my identity shared with the staff member(s).

Signature: _____ Date: _____

FOR STAFF USE ONLY:

Date Received: _____ Time Received: _____ Received by: _____

Report Received: In Person Telephone Mail (please attach) Email (please attach)

Summary of Investigation:

Response:

Respondent: _____ Date: _____ Time: _____

Method of Response: In Person Telephone Mail (see attached) Email (see attached)

Detail of Response: (Attach if Written)

Signature of Respondent: _____