FEEDBACK FORM

Date__________________

Name of Complainant (optional):	**Name of Client (optional)**
Contact phone number/address:	**Name of staff member receiving complaint:**

What happened? When did it happen? Who was involved? Who have you told about this?

What would you like to see happen?

Action taken (resolution and who was involved)

Forwarded to Clinical Director ☐ yes ☐ no Date_______________

Letter sent to client? ☐ yes ☐ no Date ______________ (attach letter if sent)

Reviewed by CAC ☐ yes ☐ no Date: _________________

Formal Grievance filed? ☐ yes ☐ no Date: ______________________

If yes, with what agency? ______________________________________

Additional Notes:

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