GRIEVANCE REPORT FORM

Return Completed Forms to:
102 E. Holme Street
P.O. Box 250
Norton, KS 67654

Patient Information

Patient Name (Last, First, Middle Initial)

Person Filing Grievance (if different from patient)

Relationship to Patient

Mailing Address (City, State, Zip Code)

Cell Phone

Home Phone

Grievance Information

Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. If you need more pages to describe the issue, please attach them to this form.

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Resolution

Please include a statement regarding the outcome desired and what you believe Norton County Hospital can do to resolve your concern.

☐ I certify that this information is true and correct.

☐ I understand that checking this box and typing my name constitute a legal signature and confirm that I am the person whose name is typed.

Signature of Patient/Person Filing Grievance **Date**