NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136
Mailing Address: PO Box 176, Wheeler, OR 97147
Telephone: 503-355-3500 | Fax: 844-720-1901

Please place your completed form in the secure Patient Feedback box near the front desk or email directly to Rinehart Clinic's Risk Manager at dbryan@rinehartclinic.org.

Rinehart Clinic is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680).
All services will be provided by the Rinehart Clinic health care team.

Today's date: ____________________

PATIENT GRIEVANCE FORM

PATIENT & COMPLAINT DETAILS

Patient Name: ____ Telephone #: ______________________

Address: ____

Person Reporting: ____

If other than patient:

Relationship to patient: _______________________________________ 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:

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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: _____________________

 Form Revised 9-3-2021

FOR STAFF USE ONLY:

Date Received:_____________ Time Received: ___________ Received by: ________________________________

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

Summary of Investigation:

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Response:

Respondent: ______________________________________ Date: ________________ Time: _______________

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

Detail of Response: (Attach if Written)

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Signature of Respondent: ____