

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 Nehalem Bay Health Center's Risk Manager at dturney@nehalembayhealth.org.

Nehalem Bay Health Center (formerly known as 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 Nehalem Bay Health Center 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:

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: _____