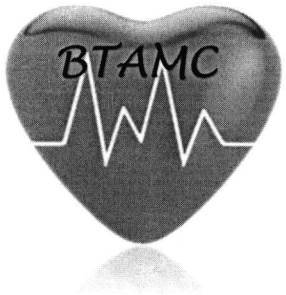

BROAD TOP AREA MEDICAL CENTER, INC.
Complaint/Grievance form

Patient Information

Patient Name: _____

Local Address: _____

Telephone#: _____ Date of Birth: _____

Complainant Information

Name of Person Initiating Complaint: _____

Address: _____

Telephone#: _____ Relationship to Patient: _____

Nature of Complaint

- ☐ Appointment/Access
- ☐ Billing
- ☐ Problem with MD/PA
- ☐ Problem W/Staff
- ☐ Laboratory
- ☐ Referral
- ☐ Policy/Procedure
- ☐ X-Ray
- ☐ Medical Care
- ☐ Other: _____

Time & Date of Incident: _____

Names of Staff Involved (If Known): _____

In your own words please tell us why you are not happy with the care or service you received:

_____

_____

_____

_____

(Please continue on a separate sheet if necessary)

As a result of your complaint, what would you like to see Happen?

_____

I understand that staff investigating this complaint may see to see and review health records, but that all information will be kept confidential. I further understand that this complaint/grievance will in no way affect any care provided.

Signature: _____ Date: _____

Thank you for taking time to bring your complaint to our attention. You should receive a response within 30 days.
Please return this to: **Broad Top Area Medical Center, Inc. 4133 Medical Center Drive, Broad Top, PA 16652 OR Fax: 814-635-7354**