TCSIG Members' WELLNESS CENTER

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PATIENT COMPLIMENT/COMPLAINT FORM

Patient Name_____ Phone Number_____

Date of Visit_____

Medical Provider Name_____

COMPLAINT COMPLIMENT (circle one)

Person reviewing the Complaint/compliment: Date of Review:

Complaint/Compliment Number:

Findings:

Action:

All complaints are handled in a confidential manner. Please either hand this to the receptionist in the TCSIG Administration office or mail it to 1176 Live Oak Blvd, Suite A, Yuba City, CA 95991