

Instructions: Complete this form and mail to:

CITCHC
Attn: Assistant Health and Human Services Administrator
P.O. Box 3190
Coos Bay, OR 97420

CITCHC Complaint Report

Name of Individual(s) filing Complaint: _____

Patient/Client: Yes No

Address: _____ Phone: _____

Specific Person or Department which Complaint is against: _____

Key individuals involved in the Complaint: _____

What happened (if more space is needed, please use an additional piece of paper):

How have your rights been violated? Please explain below:

Have you taken any other actions (besides this complaint) to address the incident? (i.e. Notified the Tribal Council, the Health Advisory Board, Community Health Representative, etc...)

Client/Patient-defined solution: (What would you like and/or what can we do?)

Client/Patient Signature(s) _____ Date _____

I hereby affirm that the information contained in this Complaint Report is true to the best of my information and belief.