
Grievance/Complaint Report Form

Patient Name: _____ Student ID # _____
Telephone #: _____ UNI email address: _____
Mailing address: _____

Person Reporting: _____
If other than patient above:
Relationship to patient: _____ Telephone #: _____
Address: _____

Date Received: _____ Time Received: _____ Received By _____

Report Received: ___ In Person ___ Telephone ___ Mail ___ Email

Specifics of Report:

Signature: _____

Summary of investigation:

Respondent: _____ Date: _____

Method of Response: ___ In person ___ Telephone ___ Mail

Detail of Response:

Signature: _____