NDFHT
Nipigon District Family Health Team

Patient/Client Concern/Complaint Form

Name of Patient/Client - (whom the concern/complaint is being made on behalf of)			
Name of Complainant -			
Relationship to Patient/Client -			
Address -			
Contact Information -	(Home)	(Cell)	(Other)
Date/Time of Concern/Complaint -			
Complaint - (please describe clearly and concisely. Use the reverse of this document for additional details.) -			
Signature of Person Receiving Complaint -			
Signature of Complainant -			
Date Submitted to NDFHT -			
Date Received by Executive Director -			