



**K'ima:w Medical Center**

Please note: return patient comment form to the Chief Executive Officer or  
Chief Operations Officer

Administration Department P.O Box 1288 Hoopa, CA. 95546

**Patient Comment Form**

Patient Name and Address <hr/> <hr/> <hr/> <hr/> Telephone number: <hr/>	Date Report Made: <hr/> Month/Day/Year  Date of Comment/Complaint: <hr/> Month/Day/Year  Time of Occurrence: <hr/> _____ <b>am/pm</b>	Specify Department: <ul style="list-style-type: none"> <li>• Medical Clinic</li> <li>• Medical Records</li> <li>• Nursing</li> <li>• Dental Clinic</li> <li>• Laboratory</li> <li>• Radiology</li> <li>• Senior Nutrition</li> <li>• PRC (Social Services)</li> <li>• Transportation</li> <li>• Outreach/ CHR</li> <li>• Ambulance</li> <li>• Pharmacy</li> <li>• Diabetes Management</li> <li>• Billing</li> <li>• Behavior Health</li> </ul>
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**Comments:**

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**over**

**To Be Completed By KMC Personnel Only**

**(Note: please attach and use additional pages if necessary)**

**Date & time Received:** \_\_\_\_\_

**Action taken to resolve Comments:**


\_\_\_\_\_  
**Employee Signature/ Date**

**If comments were not resolved to whom did you refer it to:**

**Supervisor**       **CEO**

**Date & Time received:** \_\_\_\_\_

**Supervisor/CEO Action Taken:**


\_\_\_\_\_  
**Supervisor/CEO Signature/Date**