FAIRFAX MEDICAL FACILITIES, INC. PATIENT COMPLAINT FORM

Today's Date:			
Date of Complaint:			
Patient's Name:			
Date of Incident:			
Complaint on (individua	al complaining abo	ut):	
Summary of complaint:		·	
cammary or complaint			

Summary of Actions Taken:		
outilitary of Actions Taken.		
HR Manager/Site Manager/Employees Involved	Date Received	

Please return the completed form to your local FMFI clinic or mail to Fairfax Medical Facilities, Inc. c/o
Administration, 160 N. Main St. Fairfax, OK 74637