MARYLAND
Department of Health
Office of Health Care Quality
7120 Samuel Morse Drive • Second Floor • Columbia, MD 21046-3422
Phone 410-402-8015 • Fax 410-402-8056 • ohcq.complaints@maryland.gov

COMPLAINT REPORT FORM

Complete this form if you have concerns about the health care or treatment that you or a family member received or did not receive. Answer all questions. Give complete details. Use additional sheet, if necessary. You may use this form as a guide when making a complaint by telephone. We will investigate your concerns based on the information that you provide.

You may file an anonymous complaint

Complete the following questions.

1. Name of patient/resident/client involved in the incident: _____

Date of Birth: _____

Date of Admission: _____

2. Health care facility, residence, or community treatment program involved in the incident:

Name: _____

Address: _____

Check the type of facility or program: [ ] Nursing home [ ] Adult medical day care [ ] Assisted living [ ] Hospital [ ] Home health agency [ ] Hospice [ ] Dialysis Center [ ] [ ] Ambulatory surgery center [ ] Residential services agency [ ] Medical laboratory [ ] Developmental disabilities provider [ ] Other. Please specify: _____

3. Witnesses to the incident:

Name	**Contact information, if known** (include telephone number)
_____	_____

4. Person filing complaint or reporting incident (optional).

Name: _____ **Relationship:** _____

Address: _____

Telephone: _____

May we reveal your identity during the investigation of your complaint? [ ] Yes [ ] No

5. Have you reported this incident or concern to the person in charge of the facility, residence or program? [ ] Yes [ ] No

6. Briefly describe the incident or your concerns (use additional paper if necessary):
Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate. **Note:** If this is an anonymous report, be complete since we will not be able to contact you to obtain missing information.