Resident Grievance System

Maryland Department of Health
201 West Preston Street, Room 427 A
Baltimore, Maryland 21201
1-800-747-7454

COMPLAINT FORM

Name_____ **Date of Birth**_____

Facility & Unit/Ward/Cottage_____

Complaint should include the date, time, place, and the names of possible witnesses to the incident. Please provide a detailed description of what occurred. If necessary, attach additional pages.

_____ _____

Complainant's Signature **Date Complaint Submitted**

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Signature of Person Assisting or Referring Complainant