DEPARTMENT OF HEALTH & MENTAL HYGIENE
RESIDENT GRIEVANCE SYSTEM

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, you may attach additional pages.

___________________________________ ________________________
Complainant's Signature Date Complaint Submitted

____
Signature of Person Assisting or Referring Complainant

RGS-1
Rev 7/99