The Child Center
A Circle of Care for Children and Families

GRIEVANCE PROBLEM SOLVING INFORMATION FORM

Patient Name:_____Date of Birth:_____

Phone #:_____Address:_____

Today's Date:_____

Provider Name:_____Date of Service if it applies:_____

Please explain your grievance, complaint, or concern as fully as you can. You may use more paper, if necessary.

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Tell us what you think should be done. You may use more paper, if necessary.

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Signature of Patient or Authorized Representative:_____
Please sign above so we can get records and other information we need to look at your complaint.

Send or return to The Child Center 3995 Marcola Rd., Springfield, OR 97477.

If you need assistance completing this form, please call The Child Center at: 541-726-1465.

You will receive a response from our agency within 5 working days of the date returned to The Child Center office.

3995 Marcola Road, Springfield, Oregon 97477 541-726-1465 541-726-5085 Fax
www.thechildcenter.org Outpatient 541-747-7734 541-343-2728 Fax