

PROVIDER AND CONSUMER SERVICES UNIT
DIVISION OF QUALITY ASSURANCE
OHIO DEPARTMENT OF HEALTH
COMPLAINT FORM

You may file this complaint **ANONYMOUSLY**, by **NOT** providing us your name and address. **Skip to Section II if you wish to remain anonymous.** If you remain anonymous, ODH will not be able to contact you to obtain additional information or notify you of the results of the complaint investigation.

Section I Complainant Information – Complete only if you wish to receive our acknowledgement and notification letters with the results of the complaint investigation

Complainant Name:		
Street Address:		
City:	State:	Zip:
Primary Telephone: ()	Secondary Telephone: ()	

NOTE: All person-identifiable information is confidential.

Section II Facility Information

Facility Name:		
Address:		
City:	State:	Zip:
Telephone:		

Section III Resident(s)/Patient(s) Information

Resident/Patient Name:		Date of Birth:
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Name(s):		
Name:	Date of Birth:	
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name:	Date of Birth:	
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section IV Alleged Wrongdoer(s) Information – if applicable or known

Name:	Title:
Additional Name(s)/Title:	
Name and Title:	
Name and Title:	
Name and Title:	

Section V Narrative Description

Provide a narrative description of your complaint which should include **date, time and location** of the incident. Include name and phone number of any witness(es), if applicable.