Page Content

ONLINE COMPLAINT INTAKE Fields marked with * are required

Contact Information:

Your First Name

Your Last Name

Address

City

State (e.g. PA)
PA

Zip Code (e.g. 17000)

Phone Number (e.g. 555-555-5555)

Alternate Phone Number (e.g. 555-555-5555)

Email

Complaint Type

○ New Complaint

○ Recently Lodged Complaint

Confidentiality

○ Confidentiality Requested

Relationship to Patient

Please specify if "Other":

Patient Information:

Patient First Name

Patient Last Name

Patient Date of Birth (e.g. MM/DD/YYYY)

Date of Incident (e.g. MM/DD/YYYY)

Facility Information:

Facility Name*

Facility Address*

Facility City*

Facility State* (e.g. PA)
PA

Facility Zip Code* (e.g. 17000)

Complaint Information:

Concerns discussed with:

☐ Administrator ☐ Director of Nursing ☐ Other Staff

Details (Please be as specific as possible)*

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Submit

More
(http://apps.health.pa.gov/dohforms/FacilityComplaint.aspx#)

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(http://www.pa.gov/Pages/Agency-Directory.aspx)

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