CCHD COMPLAINT FORM

Christiancountyhealth.com
417.581.7285

Information About Complainant

YOUR NAME _____
First Last MI

ADDRESS _____
Street City State Zip County

E-MAIL _____

PRIMARY PHONE NO. _____ SECONDARY PHONE NO. _____

Information About Complaint

Describe the facts and details of the complaint. In your narrative, you need to distinguish between first-hand observations based upon personal knowledge and hearsay statements obtained from others.

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_____ You may attach a separate sheet of paper if you need more space.

YOUR VERIFICATION

Our intent is to have a response to your registered concerns from the CCHD Administrator within 7-14 business days, depending on the accessibility and approval of the 5-member Board of Trustees review.

I ATTEST TO THE ACCURACY OF STATEMENTS MADE IN THIS COMPLAINT.

YOUR SIGNATURE _____

DATE _____

HOW WOULD YOU LIKE YOUR COMPLAINT RESOLVED

_____

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THIS IS A PUBLIC DOCUMENT

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Date Complaint Received: _____

How was this complaint resolved?

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Date_____

Administrator Signature_____

Board Chairman Signature_____

Board Vice Chairman Signature_____

Board Treasurer Signature_____

Board Secretary Signature_____

Board Member Signature_____