

STATEMENT OF GRIEVANCE

WHATCOM COUNTY MEDICAL SOCIETY
202 E. Holly St., #219
Bellingham, WA 98225
(360) 676-7630

Date _____

Name _____

Address _____

Telephone _____ Patient's Age _____ Sex _____

List the name(s) of those with whom you have a grievance:

Was this the first time the patient was seen by the above? _____

List the names of any others the patient has seen for this condition (include dates):

Briefly state your grievance: _____

Have you discussed, or attempted to discuss this matter with the physician? _____

If so, what were the results of your contact (of attempted contact)?

What, in your opinion, could the Grievance Committee do that would satisfy your grievance? _____

Signed _____ Date _____

(Use reverse side if more space is needed)