Friends of Family Health Center

501 South Idaho Street, Suite 100
La Habra, CA 90631
(562) 690-0400
www.fofhealthcenter.org

Patient Grievance Form

Member Name:	Member ID Number:	Date of Birth:
Address:	City:	Zip Code:
Phone Number:	Email Address:	
Name of Person filing if different than above (Patient, Parent, or Guardian):		Phone Number:
Describe the concern in detail: (Use additional sheets if necessary)		Date of Concern:
How have you tried to resolve the concern? (Use additional sheets if necessary)		
What can we do to resolve this concern? (Use additional sheets if necessary)		
Do you have any physical disabilities that need accommodation?		
Do you have a medical problem that needs attention in the next three (3) days, or are you in severe pain?		
Signature:		