The Wellness Plan
Complaint/Resolution Form

Please Print All Information:

Date_____ Name_____ Address_____

City_____ Phone #_____ Medical Center_____

MR#_____ DOB_____

Complaint/Concern:_____

Signature_____

Followup:_____

Signature_____ Date_____

Resolution_____

Medical Center Manager _____ Date_____

Received By Compliance Officer_____ Date_____

Comments_____

Received By Quality Coordinator_____ Date_____