

Action Brace and Prosthetic, Inc.

PATIENT COMPLAINT FORM

DATE: _____

PATIENT NAME: _____

(Please print clearly)

COMPLAINT (Please include the date the complaint occurred):

(If you need additional space, please attach a separate piece of paper.)

To be completed by the practitioner or facility representative

ACTION TAKEN:

BY: (Please print clearly)

_____ **DATE:** _____

SIGNATURE: _____

SUPERVISOR FOLLOW UP:

RESULTS OF REVIEW:

SIGNATURE: _____

DATE: _____