



Washington State Department of  
**Health**  
 Health Systems Quality Assurance  
 Office of Customer Service  
 PO Box 47857  
 Olympia, WA 98504-7857

## Complaint Intake Form

Please complete this form as thoroughly as possible.  
 If you have any questions please call 360-236-2620.

1. What is the name and address of the facility you are filing a complaint about?		
Name:		
Address:		
City:	State:	Zip Code:
2. What is your name, mailing address, telephone number, and email address?		
Last:	First:	Middle:
Address:		
City:	State:	Zip Code:
Daytime Phone:	Email:	
What is your employee status with this facility? (This information to be used for internal administrative purposes only)		
Never an Employee: <input type="checkbox"/>	Former Employee: <input type="checkbox"/>	Current Employee: <input type="checkbox"/>
3. What is the name, date of birth and gender of the affected patient/client?		
Last:	First:	Middle:
Date of Birth:	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
4. What is your relationship to the patient/client?		
5. If the patient was in a facility, in what department, or on what unit or floor did the incidents(s) or problem(s) occur?		
6. What date was the patient/client admitted to the facility?		
7. Is the patient/client still in the facility or still receiving services? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		
8. What date was the patient/client discharged from facility services:		
9. What were the date(s) and time(s) that the incident(s) or problem(s) occurred?		
10. Please describe what happened in detail. (If additional space is needed please attach a separate piece of paper.)		
11. Please summarize your primary concerns:		
12. Have you filed a complaint with anyone at the facility? If so, with whom, when and have you received a response?		
13. Have you reported this to, or filed a complaint or action with, any other agency or organization? Such as law enforcement, Adult Protective Services, professional licensing boards? If so, which agencies, when and what were the actions or findings?		

You may submit this form by mail, email or fax.

**Mail:**

Health Systems Quality Assurance

Complaint Intake Unit

PO Box 47857

Olympia, WA 98504-7857

**Mark clearly on the envelope “Confidential”**

**Email:** [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

**Fax:** 360-236-2626