



Washington State Department of

Health

Health Professions Quality Assurance

P.O. Box 47865

Olympia WA 98504-7865

Health Systems Quality Assurance Complaint Form

Today's Date: _____

1. Your Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Work (_____) _____ - _____ Home (_____) _____ - _____

2. Information about the Facility or Health Care Professional

Type of facility or profession: _____

Name of facility or professional: _____

Address: _____

City: _____ State: _____ Zip: _____

3. Resident/Guest/Patient Information

Full Name (if different than above) _____

Date of Birth (of patient, if complaint involves a patient) _____

Date of incident: _____

4. Please describe your complaint in the space below. Include the name, title and phone number of other patients, witnesses or staff members involved in the incident. Email completed form to the Customer Service Center at HPQA.CSC@doh.wa.gov, or fax to 360.236.4818, or mail to:

Washington State Department of Health

P.O. Box 47865

Olympia WA 98504-7865.

Please attach any supporting documentation and additional sheets if necessary.

		<i>For Department of Health use only:</i>	
Reviewed for multiple authority applications	date _____	name _____	_____
Routed to:	Multi-authority coordinator _____	date _____	_____
	Office _____	date _____	_____
	Office _____	date _____	_____
	Office _____	date _____	_____