



# Health Care Providers and Facilities Complaint Form

Date:

**Your Information:**

Name:

(First Name)

(Middle Name)

(Last Name)

Physical Address:

(Street Address)

(City)

(State)

(Zip Code)

Mailing Address:

(Street Address)

(City)

(State)

(Zip Code)

Phone: (     )     -     

Home:  Cell:  Work:

Alt. Phone: (     )     -     

Home:  Cell:  Work:

Fax: (     )     -     

Email:

Are you filing this report on behalf of a Business or Facility? Yes  No

If yes, Company / Facility Name:

The identity of a whistleblower who complains in good faith to the Department of Health about the improper quality of care by a health care provider or in a health care facility as defined in WAC [246-15-020](#) shall remain confidential under provisions of [RCW 43.70.075](#) unless confidentiality is waived. Whistleblower means a consumer, employee or health care professional.

**Information about Health Care Providers and/or the Facility**

Please provide as much information as possible regarding the provider(s) and/or the facility where you received care.

Type of Profession / Title:

Full Name of the Individual Provider:

Address: (Street Address) (City) (State) (Zip Code)

Phone: ( ) -

Type of Facility:

Name of Facility:

Address: (Street Address) (City) (State) (Zip Code)

Phone: ( ) -

Room Number (If applicable): Department (If applicable):

Date(s) of Service or Stay:

What is your employment status with the facility? *(This information is used for internal administrative purposes only)*

Never an Employee  Former Employee  Current Employee

**Patient/Guest/Client Information:**

Name: (First Name) (Middle Name) (Last Name)

Date of Birth:

Date of Incident:

What is your relationship to the patient/guest/client?

Have you filed a complaint with anyone at the facility? If so, with whom, when and have you received a response?

Yes  No

If yes, with whom: When:

Comments:

Have you reported this to or filed a complaint or action with any other agency or organization? For example law enforcement, Adult Protective Services, Professional licensing boards. If so, which agencies, when and what were the actions or findings?

Yes  No

Comments:

Please describe your complaint in the space below. Include the name, title and phone number of other patients, witnesses or staff involved in the incident. (Attach additional complaint information if necessary)

Return this completed form to the Washington State Department of Health via Mail, Email or Fax.

Health Systems Quality Assurance  
Complaint Intake Unit  
PO Box 47857  
Olympia, WA 98504-7857  
[HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)  
Fax: 360-236-2626

Feel free to call us at 360-236-2620 with any questions. Additional information regarding the complaint and disciplinary process is available on our website at [www.doh.wa.gov](http://www.doh.wa.gov).