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PUBLIC HEALTH
Health Care Regulation & Quality Improvement

Complaint Intake Form

P.O Box 14450
Portland, OR 97293
Voice 971-673-0540
FAX 971-673-0556
TTY 971-673-0372
http://www.healthoregon.org/hcrqi

Thank you for sharing your concerns with the office of Health Care Regulation and Quality Improvement.

The information provided below will be carefully reviewed against the applicable Oregon Administrative Rules and/or Code of Federal Regulations for the specific facility or agency type this complaint is about. The review will determine if there are potential violations of those requirements and if this is the office with jurisdiction to take further action.

You will be notified in writing of the results of the review. The letter will inform you what action this office has authority to take, which may include an unannounced, onsite investigation. If it is determined that the concerns fall under the jurisdiction of another agency or organization the letter will provide you with that information.

It is important for you to know that your identity as the complainant is maintained confidentially. This office is prohibited from releasing complainant information and the complaint systems are designed to protect that anonymity.

Please complete this form as thoroughly as possible. If you have any questions please call **(971)673-0540**.

1. What is the name and address or city of the facility or agency you are filing a complaint about?			
Name:			
Address, City, State & ZIP:			
2. What is your name, mailing address, telephone number, and email address?			
Last :	First:	Middle:	
Address, City, State & ZIP:			
Daytime Telephone:	Email:		
What is your employee status with this facility/agency? *(This information to be used for internal administrative purposes only.)*	Never an Employee ☐	Former Employee ☐	Current Employee ☐

3. What is the name, date of birth and gender of the affected patient/client? (If more than one patient/client list all on separate attachment.)		
Last :	First:	Middle:
Date of Birth:	Male ☐	Female ☐
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 incident(s) or problem(s) occur?		
6. What date was the patient/client admitted to the facility/agency?		
7. Is the patient/client still in the facility or still receiving agency services?	Yes ☐	No ☐
8. What date was the patient/client discharged from facility/agency 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 separate piece of paper.)		

11. To summarize, what do you believe the facility/agency did wrong?
12. Does anyone else have first hand knowledge of the incident(s) or the problem(s)? Such as facility/agency staff, volunteers, family members, other patients or clients, visitors? Please list the names, relationship/title and if you know it, telephone contact information for those witnesses/individuals?
13. Have you filed a complaint with anyone at the facility/agency? If so, with whom, when, and have you received a response?
14. 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:
Attention: Health Care Regulation and Quality Improvement
P.O Box 14450
Portland, OR 97293
Mark clearly on the envelope "Confidential"

Email: mailbox.hclc@state.or.us

Fax: (971)673-0556

If you need this information in an alternate format,
please call our office at (971)673-0540 or TTY (971)673-0372.