LEE COUNTY COOPERATIVE CLINIC
PATIENT COMPLAINT FORM

The purpose of this form is to assist you in filing a complaint with Lee County Cooperative Clinic regarding any denied services, mistreatment by a staff member, medical services or any other complaint that should be addressed by our administrative staff. LCCC will make every effort to investigate and resolve your complaint in a timely manner. More information may be needed.

1. Patient Name and Address: Date: _____

   Name: _____
   Address: _____
   Phone Number: Home ( ) _____ Work ( ) _____
   Message ( ) _____ Email Address: _____

2. If this Complaint is being made on behalf of someone else please state your name, address and relationship to the person that you are making the complaint on behalf of.

   Name: _____
   Address: _____
   Phone Number: Home ( ) _____ Work ( ) _____
   Message ( ) _____ Email Address: _____

3. Which clinic does your complaint concern? **Please check one of the following?**

☐ Marianna ☐ Hughes ☐ Lakeview ☐ Madison

3. Is this complaint being made on behalf of another person? Yes ☐ No ☐
   If yes, please state your relationship to this person. _____

4. Date Incident occurred or when you first became aware of the problem: _____

5. Please state your complaint and give as many details as possible. If you need additional space, please attach an additional sheet or turn on back.

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Complainant