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| **COMPLAINT INFORMATION** | | |
| **Check campus and complaint issue** | | |
| * **SALEM CAMPUS** | * **JUNCTION CITY CAMPUS** | |
| * Patient care | * Staff Interaction |  |
| * Customer Service | * Policy or Procedure |  |
| * Visitation | | |
| * Other (Please specify): | | |
| **Please provide the following** | | |
| **Please print** | | |
| Date: | | |
| First Name: | Last Name: | |
| Check and provide your preferred method of contact | | |
| * Cell Phone: | * Home Phone: | |
| * Email Address: | | |
| Mailing address | | |
| Street/PO Box: | City/State: | Zip: |
| If this is in reference to a patient, please provide the following | | |
| Patient Name: | Unit: | |
| **Please describe your complaint** | | |
| When possible include the date, location, name of staff involved, and any other details that will help us investigate the incident. | | |
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Methods to submit this form:

1. Email: [osh.ombudsservices@dhsoha.state.or.us](mailto:osh.ombudsservices@dhsoha.state.or.us)
2. Mail: OSH Ombuds

Oregon State Hospital 2600 Center Street NE Salem, OR 97301

1. Drop off: ***To ensure confidentiality please place this form in a sealed envelope labeled OSH Ombuds***
   * Salem: Lobby drop box
   * Junction City: Lobby drop box