Oregon WIC Program
800 NE Oregon Street, Suite 865
Portland, OR 97232
Voice: 971-673-0040
FAX: 971-673-0071
TTY: 711

COMPLAINT FORM

Customer or Staff may complete this form – Your concerns will be treated with privacy

Customer name: _____ ID # if applicable:_____

Customer address: _____
Number Street City Zip

Email Address: _____

Customer Telephone: Home: (_____)_____ Other:(_____)_____

Please tell us what the problem is and what you would like done about it.
Please use back of page if needed. Thank you for providing this information.

Date of Complaint: _____ ☐ Completed by Customer ☐ Completed by Staff

Signed: _____

THIS SECTION TO BE REVIEWED AND COMPLETED BY MANAGER/SUPERVISOR

Date Received: _____ Reviewed by: _____

Resolution:

Date customer notified: _____ of resolution, via: ☐ phone ☐ mail ☐ email ☐ other _____

Check program involved: ☐ STD/HIV/Hep C ☐ TB ☐ ECS ☐ Immunizations ☐ WIC

STAFF USE ONLY:

Type of Complaint: ☐ **Access to services** ☐ **Quality of care** ☐ **Billing issue** ☐ **Staff issue**
☐ **Delay/wait time** ☐ **Communications** ☐ **Appropriateness of care**

DETAILS OF COMPLAINT, continued:

MANAGER/SUPERVISOR REVIEW, continued: