HEALTH SERVICES
KODIAK AREA NATIVE ASSOCIATION

Patient Grievance Form

Full Name: _____ Date of Birth: _____

Address: _____ Contact Number: _____

Please check one: Are you the: ☐ Patient ☐ Family Member ☐ Friend

What is the best way to reach you? _____

What are the best hours to reach you? _____

Details of the Complaint or Concern: (Please be as specific as possible and include names, dates, times, and specific actions or concerns. Use the other side of this form if you need more room. Attach any relevant documents.)

_____

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Attached documents include:

_____

_____

_____

We thank you for bringing this issue to our attention. We will use your feedback to ensure that we are meeting our mission To Elevate the Quality of Life of the People We Serve. KANA patients/clients have the right to file a complaint or grievance without worrying about retaliation or humiliation.

_____ _____

Signature of Patient or Legally Designated/Personal Representative Date

Authority: _____

(If signed by Legally Designated/Personal Representative)