Virginia Garcia Memorial
HEALTH CENTER

Because We Care

This form may be completed by anyone for issues regarding quality of care or service or clinical documentation issue. This form may be submitted to an VGMHC employee or may be mailed to: Quality Assurance Manager, PO Box 6149, Aloha, OR 97007

Please Check Site:

☐ Beaverton
☐ Cornelius
☐ Hillsboro
☐ McMinnville
☐ Newberg
☐ Mobile Van

☐ SBHC:_____

☐ Other: _____

Please Check Department:

☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision ☐ OB

☐ Other:_____

This is a:

☐ **Compliment:** Congratulate our staff on a job well done.
☐ **Concern:** expression of worry about safety or quality of care, services, or processes (ex: tripping hazard)
☐ **Complaint:** expression of dissatisfaction with safety or quality of care, services, or processes (ex: a patient having to wait an hour for his/her appointment)
☐ **Patient Grievance:** formal statement of serious complaint such as a violation of rights or care that puts your health in danger (ex: discrimination, abuse)

Date of Occurrence: _____ Date of Report: _____

List full names of individuals directly involved:

Patient Name(s)	DOB	Employee Name(s)
_____		_____
_____		_____
_____		_____

Please share your experience.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of person completing this form: _____ **Date:** _____

Phone Number:_____ **Email:**_____

Best time to be reached (Please check all that apply):

☐ Mornings (9am-Noon) ☐ Afternoons (Noon-5pm) ☐ Evenings (5pm-9pm) ☐ Weekends