

MINNESOTA ADULT DAY CENTER

CLIENT COMPLAINT FORM

CLIENT INFORMATION

Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____/____/____
Address: _____	City: _____	State: _____ Zip: _____
Telephone: _____	Email address: _____	
Other Information: _____		

COMPLAINANT INFORMATION (If Complainant is **not** the Patient)

Name: _____	(May remain anonymous)	
Address: _____	City: _____	State: _____ Zip: _____
Telephone: _____	Email address: _____	
Relationship to Patient: _____		

Complaint Occurrence Date: ____/____/____ **Complaint Report Date:** ____/____/____

Description of Complaint: Briefly describe what occurred. Please limit comments to the facts: 1) who was involved, 2) what happened, 3) where it occurred, and 4) how/why it occurred. Type or print legibly.

Identify any witnesses to the occurrence by name (and phone number, if available):

Please note that MINNESOTA ADULT DAY CENTER **will not retaliate** to whomever complete this form.

Return the completed form by one of the following methods:

- **FAX** to 507-205-7390
- **EMAIL** to admin@mnaduldaycenter.com
- **MAIL** to our Rochester office:

MINNESOTA ADULT DAY CENTER
330 ELTON HILLS DR NW #210
ROCHESTER MN 55901