Valley-Wide Health Systems, Inc.

Customer Compliment Form

Person Making Compliment

Your Name:_____

Relationship to Patient:_____ Phone Number:_____

Date of Event:_____ Location of Event:_____

Details of your Compliment (Please provide as much detail as possible; include names, dates and locations)

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Signature of Patient or Representative_____ Attach additional sheets if needed

----------Office Use Only----------

Employee Who Filed Compliment_____ **Date Filed**_____

Was Employee(s) Acknowledged ☐ **Yes** ☐ **No**

SUBMIT ALL PATIENT COMPLIMENT FORMS AND RELEVANT INFORMATION TO THE CLINICAL QUALITY COORDINATOR

Revised 7/15