# PATIENT GRIEVANCE FORM

Please complete and return to:
**Guest Relations-SwedishAmerican Hospital**
**1401 E. State, Rockford, IL 61104**
FAX: 815-967-5698

Today's Date________________________________ Department______________________________________________

Patient Name ___________________________________________________________________________________

Patient Address__________________________________________________________________________________

Home Phone ___________________________________ Cell Phone __________________________________________

Person completing form, if not patient____________________________________________________________

Your address and phone_______________________________________________________________________

Please provide a detailed explanation of your concern. Please describe who, what, when where, and how if possible.

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Please describe your expectation for resolution. Use the back, if necessary.

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If you prefer, you may call the Guest Relations office at 779-696-3898. You may also report concerns directly to the Illinois Department of Public Health at 1-800-252-4343 or the Joint Commission at 1-800-994-6610.