PROVIDER AND CONSUMER SERVICES UNIT
DIVISION OF QUALITY ASSURANCE
OHIO DEPARTMENT OF HEALTH
COMPLAINT FORM

You may file this complaint **ANONYMOUSLY**, by **NOT** providing us your name and address. **Skip to Section II if you wish to remain anonymous**. If you remain anonymous, ODH will not be able to contact you to obtain additional information or notify you of the results of the complaint investigation.

Section I Complainant Information – ***Complete only if you wish to receive our acknowledgement and notification letters with the results of the complaint investigation*** ***Red outlined fields are mandatory**

Complainant Name:		
Street Address:		
City:	State:	Zip:
Primary Telephone: ( )	Secondary Telephone: ( )	

NOTE: All person-identifiable information is confidential.

Section II Facility Information

*Facility Name:	*Facility Type:	
*Address:		
City:	State:	Zip
Telephone:		

Section III Resident(s)/Patient(s) Information

Resident/Patient Name:		Date of Birth:
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? ☐ Yes ☐ No	

Additional Name(s):

Name:	Date of Birth:
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? ☐ Yes ☐ No
Name:	Date of Birth:
Relationship to Resident/Patient:	Is the Resident/Patient still in the facility? ☐ Yes ☐ No

Section IV Alleged Wrongdoer(s) Information – if applicable or known

Name:	Title:

Additional Name(s)/Title:

Name and Title:
Name and Title:
Name and Title:

***Section V Narrative Description**

Provide a narrative description of your complaint which should include **date, time and location** of the incident. Include name and phone number of any witness(es), if applicable.

Submit this form to ODH