



Client Grievance Form

Name: _____ Phone Number: _____

Email: _____

ImmaCare Program: _____

Did you speak with an ImmaCare staff person about this concern? ____ yes ____ no

If yes: Who: _____ When: _____

Result: _____

Please provide a summary of the problem that you would like to be reviewed. Please be as specific as possible and include names, dates, times, and places when possible. Include any information you feel is important. Your grievance will be reviewed in a timely manner.

(Attach additional sheets as needed)

Signature

Date