1010 Main Street, Suite 300
Buffalo, NY 14202
Tel: (716) 896-2470 Fax: (716) 218-4010

Patient Grievance/Complaint Report

Please fill out the criteria below with a clear description of what happened. Mail to the address listed at the top of this form or fax to the above listed fax number.

Name of Person making complaint: _____

Address: _____

_____

Phone: _____ **Contact Person Name:** _____

Name of WNYBC employee recording complaint: _____

Date of report: _____ **Date of Occurrence:** _____ **Time of Occurrence**: _____

Relationship to patient of person filing complaint: _____

Witnesses to occurrence (WNYBC staff, family, another patient, etc.): _____

_____

Complaint (facts): _____

_____

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