THE FAMILY CENTER – FAMILY COUNSELING OF COLUMBUS
1350 15th Avenue
P. O. Box 1825
Columbus, GA 31902-1825
(706) 327-3238

CLIENT GRIEVANCE REPORT

Date complaint received: _____ Form of complaint: ( ) In person ( ) Telephone ( ) Verbal ( ) Written

If complaint was made in person, was client given a copy of grievance procedure? ( ) Yes ( ) No

Client reporting the grievance: _____

Name of person completing form (if not the client): _____ Date: _____

Specific complaint (WHO, WHAT, WHERE, WHEN, WHY, HOW): _____

_____

_____

_____

_____

Report given to: _____ Date: _____
Name of Supervisory Staff receiving the report

COMPLAINT RESOLUTION

Date reviewed by designated manager: _____

Recommended course of action: _____

_____

_____

_____

Person(s) responsible: _____

_____

Date recommendations are to be completed and reported back: _____

Further action needed: _____

Date client notified of resolution: _____

Date reviewed by Quality Council: _____ Comments: _____

_____

_____