Fort Collins Community Clinic CLIENT GRIEVANCE FORM

GRIEVANT INFORMATION	
NAME	DATE OF BIRTH
PHONE NUMBER	DATE FORM SUBMITTED
MAILING ADDRESS	MHP PROGRAM (If known)

DETAILS OF EVENT LEADING TO GRIEVANCE	
DATE, TIME, AND LOCATION OF EVENT	WITNESSES if applicable
ACCOUNT OF EVENT	VIOLATIONS
Provide a detailed account of the occurrence. Include the names of any additional persons involved.	Provide a list of any policies, procedures, or guidelines you believe have been violated in the event described.

PROPOSED SOLUTION

Please retain a copy of this form for your own records. As the grievant, please provide your signature below, as it indicates that the information you've included on this form is truthful.

SIGNATURES	
CLIENT SIGNATURE	DATE
RECEIVED BY: PRINTED NAME AND SIGNATURE	DATE