ATIKOKAN HEALTH AND COMMUNITY SERVICES

Feedback Form – Members of the Public

Please complete all of this form. You will receive a verbal or written response within five (5) days of the Atikokan Health and Community Services having received the complaint.

Your Name	
Patient's / Resident's Name *(if you are not the patient or resident)*	
Your email	
Your Phone #	

Do you believe there was a Breach of Privacy? ☐ **Yes** ☐ **No**	**Has this been shared with the Privacy Officer?** ☐ **Yes** ☐ **No**

Date of Incident	
Time of Incident	

Please describe what happened & who was involved.
Please provide any information, which you think, will help us resolve the situation.

Please tell us what you would like to see happen in order to resolve the situation

Date & Time Feedback was Received	
Feedback Form Received by *(name of manager / supervisor)*	

AHCS FOLLOW UP ACTIONS	
Date & Time of Initial Response to Complainant	
AGH Staff Initial Response by *(name of manager / supervisor)*	
Action / Investigation Notes:	
Date & Time Feedback Resolved / Closed	
Manager Signature	