



St. Thomas East End Medical Center Corporation
 4605 Tutu Park Mall, Suite 207
 P.O. Box 503177
 St. Thomas, VI 00805-3177

Tel: (340)775-3700
 Fax: (340)777-7927

“Your Health is our First Priority”

Patient Grievance Form

Patient Name: _____ Date of Request: _____

Pt # _____ Date of Birth: _____ Phone # _____

Person Initiating Complaint: _____ Phone # _____

Date: _____ Time: _____ Relationship to patient: _____

Staff involved in grievance: _____

Please describe your grievance in detail including dates/names:
 (Please attach any additional documentation)

Type of grievance (Check all that apply)

Patient Care Factors

- Quality of Care
- Timeliness of Care
- Teaching
- Other

Staff Factors

- Courtesy
- Communication
- Privacy
- Other

Organizational Factors

- Waiting Times
- Cleanliness
- Billing Charges
- Other

Medical Staff

- Quality of Care
- Timeliness of Care
- Accessibility
- Other

If Other, specify: _____

What action are you requesting?
(Please attach any additional documentation)

Signature: _____ Date: _____

Please print relationship to patient (if signed by a personal representative of patient): _____

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days.

Mail or email the completed signed form to: Attention: Public Relations Officer
St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177
Email: ewebster@steemcc.org

OFFICIAL USE

Name / department of person initiating this record: _____

Referred to:

Manager/Supervisor Risk Manager Executive Director Other: _____

Follow-Up Action taken: _____

Public Relations Signature: _____ Executive Director Signature: _____