Please address
all correspondence

Government of Samoa
Ministry of Health

Office of the Chief Executive Officer
Private Mail Bag, Motootua
Tel: (685) 68100
Or 68102
Facsimile: (685) 26.553

PATIENT COMPLAINT/GRIEVANCE REGISTRATION FORM

Name of Complaintant: _____
(*May be the patient; designated friend/family member, etc).*
Date: ___/___/_____
Name of Patient: _____
Date of Birth: ____/____/_____ **Gender:** M/F
Patient Hospital No.: _____ **Country of Residence:** _____

Address: _____ **Email:**_____
Telephone No.: (Home /Work No.): _____ **(Mobile No.):** _____
The best way to contact me is: Email/Telephone (Home/Work/Mobile)/Post Mail

Name of Health Service Provider: _____
Type of Health Service Provider: _____ **Organization:** _____
(eg. Doctor, nurse, dentist, general practitioners, etc.) *(eg. NHS, NFKS, SHFA, MOH, etc)*

Please provide your complaint in detail including dates/names/location: (attach any additional documentation).

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_____ _____
Name & Signature of Complainant ***Name & Signature of Health Official Receiving Complaint***

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PATIENT COMPLAINT/GRIEVANCE FORM (CONSENT)

Note:

The Ministry of Health will review all complaints that come to our office. We consider each complaint important and have in place a process for redress. For the purposes of the investigation, it will be more effective to be able to disclose your name when investigating the complaint with the concerned health provider. If you are fine with us disclosing your name during the investigation of your complaint, please sign your name in Section 1 as an indication of your permission. However, if you do NOT want us to disclose your name when investigating your complaint please sign your name in Section 2. We assure you that this will be kept confidential.

[***PLEASE DO NOT SIGN BOTH STATEMENTS]***

1. ***If you agree to allow the Ministry of Health to disclose your name while investigating the complaint, please sign below:***

   I give the Ministry of Health permission to disclose my name while investigating my complaint with the concerned health service provider.

   _____ _____/_____/_____
   Signature of Complainant **Date**

   _____
   Signature of Patient/Parent/Legal Guardian

OR

2. ***If you would like your name to remain Confidential and you do not want to disclose your name during the investigation of this complaint, please sign below:***

   _____ _____/_____/_____
   Signature of Complainant **Date**

   _____
   Signature of Patient/Parent/Legal Guardian

For Office Use Only

Health Provider Name: _____ **Hospital No.:** _____

Type of Health Provider: _____ **Referred to:** _____
(e.g. Medical Council/Dental Council/Pharmacist Council/Nursing and Midwifery Council/Health Registrar)

Certified by Director General: _____

Official Stamp: _____