



Community Health Care Concerns

Date: _____ Time: _____

Caller's Name: _____

(Caller may wish to remain anonymous which is acceptable. Do not ask for contact info if anonymous)

Contact Information:

Phone: _____ Email: _____

Community: _____

Concern:

Office Use Only

Concern Type:

Health Care in general

Hospital (wait times, staff, emergency, quality of care)

Access to doctor

Concern about a clinic

Staffing in any location

Other

PCN staff initials: _____