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| **COMPLAINT INFORMATION** |
| **Check campus and complaint issue** |
| * **SALEM CAMPUS**
 | * **JUNCTION CITY CAMPUS**
 |
| * Patient care
 | * Staff Interaction
 |  |
| * Customer Service
 | * Policy or Procedure
 |  |
| * Visitation
 |
| * Other (Please specify):
 |
| **Please provide the following** |
| **Please print** |
| Date: |
| First Name: | Last Name: |
| Check and provide your preferred method of contact |
| * Cell Phone:
 | * Home Phone:
 |
| * Email Address:
 |
| Mailing address |
| Street/PO Box: | City/State: | Zip: |
| If this is in reference to a patient, please provide the following |
| Patient Name: | Unit: |
| **Please describe your complaint** |
| When possible include the date, location, name of staff involved, and any other details that will help us investigate the incident. |
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Methods to submit this form:

1. Email: osh.ombudsservices@dhsoha.state.or.us
2. Mail: OSH Ombuds

Oregon State Hospital 2600 Center Street NE Salem, OR 97301

1. Drop off: ***To ensure confidentiality please place this form in a sealed envelope labeled OSH Ombuds***
	* Salem: Lobby drop box
	* Junction City: Lobby drop box