

**United Indian Health  
Services**

**Client Complaint Form**  
(to be completed by the Client/client's family  
member/care taker)

United Indian Health Services, Inc. welcomes client complaints as an opportunity to improve client care. All clients have the right to make a complaint(s) relating to the delivery of health care. No complaint is considered too small. Making a complaint will not compromise access to future care.

Client's Name	Date of Birth
Address	Date of Incident/ Daytime Phone
City      State      Zip	Section and Site where incident occurred

Describe in your own words what happened:

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Attach separate sheet if necessary

Person(s) witnessing incident:

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Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Person completing form for client,  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return or mail to:      UIHS Quality Improvement Section, 1600 Weeot Way, Arcata, CA 95521