UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

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SALT LAKE CITY, UT 84114-4103
(801) 273-2994
(800) 662-4157 toll free
(801) 274-0658 Fax
HealthFacilityComplaint@utah.gov

COMPLAINT FORM

NAME

PHONE NUMBER | EMAIL ADDRESS

ADDRESS | CITY | STATE | ZIP

☐ ANONYMOUS: By choosing to remain anonymous you will not be able to inquire the status of the investigation nor will you receive any results of the investigation.

FACILITY/PROVIDER INFORMATION

FACILITY/AGENCY NAME | ADDRESS

RESIDENT INFORMATION

RESIDENT/PATIENT NAME

DATE OF BIRTH | RELATIONSHIP TO RESIDENT

COMPLAINT INFORMATION

Is the resident still in the facility or receiving services through the agency? ☐ YES ☐ NO

If the incident occurred in a hospital emergency room was the patient admitted to the hospital from the emergency room? ☐ YES ☐ NO

Have you reported your concerns to any other agencies? ☐ APS ☐ OMBUDSMAN ☐ LAW ENFORCEMENT

Have you spoken with anyone at the facility/agency regarding your concerns? ☐ YES ☐ NO

If yes , who did you speak with and has there been any change?

Provide as much information as possible regarding your concerns including date(s), time, names of all individuals involved and their titles, names of witnesses and their contact information, where the incident(s) occurred, etc. Select the box below if you need to attach additional pages of supporting documentation. The response and timing of any investigation by the State Agency will be based upon the information you provide.

☐ **Additional documentation will be attached to my complaint.**

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