Oklahoma State Department of Health
123 Robert S. Kerr Avenue Ste. 1702
Oklahoma City, Oklahoma 73102
Complaint Hotline: 1-800-234-7258
(24 hours, 7 days a week)

Complaint and Incident Division
Medical Facilities Service
MedFacComplaints@health.ok.gov

MEDICAL FACILITY COMPLAINT FORM

Complete one complaint form for each facility.

1. Facility Information

Facility Type (Select the facility type associated with this complaint)

- ◯ Home Health
- ◯ CLIA
- ◯ Ambulatory Care Center
- ◯ Hospice
- ◯ Hospital
- ◯ ESRD
- ◯ Other (OPT, Portable X-ray, CORF, CMHC)

Name of Facility	**Phone Number** (xxx)xxx-xxxxx
Address	
City	**State** / **Zip Code**

2. Complainant Information

I WISH TO REMAIN ANONYMOUS ☐ **Yes** (Move to Step 3. Complainant will not receive a letter of the findings.)

First Name	**Last Name**	**Phone Number** (xxx)xxx-xxxx
Address		
City	**State**	**Zip Code**
Email Address:		

3. Patient Information

First Name	**Last Name**	**Phone Number** (xxx)xxx-xxxx
Address		
City	**State**	**Zip Code**

4. Incident Details

Date of Incident	**Time of Incident** A.M. ☐ P.M. ☐
Perpetrator Name, if known:	
Is the Person/Patient still receiving care from the facility reported on Item #1? Yes ☐ No ☐	
If NO, please provide discharge date and current location. (Include the facility name if applicable and the address if the address is different from the information provided in step 3.)	Discharge Date: Location:

5. Other Involved Parties

LIST anyone else involved including other victims, witnesses, etc.
(i.e. Other Victims, Staff, Volunteers, Patients, Visitors, Family Members, etc.)

First Name	Last Name	Phone Number or Email Address

6. Previous Contact with Agency/Facility

Has this complaint been addressed with the agency/facility? ☐ Yes ☐ No (**If No**, skip to Step 7.)

If yes, provide name and title of the agency staff and any steps taken to address the issue.

Name	**Title**	**Date**

Steps taken by Agency/Facility to remedy situation

7. Contact with Other Agencies

Has another agency or law enforcement been contacted about this incident? ☐ Yes ☐ No

Agency	**Report/Incident Tracking Number**

8. Desired Outcome What is the desired Outcome for this Complaint?

9. Incident Description

Provide a brief description of the incident/occurrence. include details such as who, what, when, where, and why. Also include the time, date, and shift of the occurrence, involvement of any staff and/or patients, and the frequency/pervasiveness of the allegation. Please indicate if you have pictures, videos, or other documentation that can be provided.

Selecting “Reset Form” will clear all entered information. Be aware that this will delete all entries, requiring you to re-enter the information.

Save an electronic copy by selecting “Save Form.” Save it to your computer or a personal USB device. **Do not save it to a public computer.**

Save a hard copy by selecting “Print Form.” If you prefer to mail the form, send it to:

Oklahoma State Department of Health
Complaint and Incident Division
Medical Facilities Service
123 Robert S. Kerr Avenue
Suite 1702
Oklahoma City, Oklahoma 73102

Submit the form to the Oklahoma State Department of Health, Complaint and Incident Division via email. Additional files may be attached to the automatically generated message.