RIVERSIDE HEALTH CARE FACILITIES INC - “C.A.R.E” PROGRAM

NAME: _____

ADDRESS: _____

_____

PHONE: _____

DATE/TIME: _____

Nature of complaint/concern/compliment *(if required attach additional pages):*

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_____Signature:_____

This portion of the form to be used by the hospital/health centre only:

1. Form forwarded to the applicable manager(s)

2. What actions have been taken (to be completed by the manager).

3. What further actions are recommended?

Additional Comments:

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RIVERSIDE HEALTH CARE FACILITIES INC.
Attention: Administration
110 Victoria Avenue
Fort France, ON P9A 2B7
Phone (807)274-4801 - Fax: (807)274-2898
e-mail: riverside@rhcf.on.ca