SOUTHERN INDIAN HEALTH COUNCIL, INC.
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www.SIHC.org

# Experience Feedback Form

Please feel free to provide compliments, concerns, and suggestions to *let us know how we are doing* - if we scored big by being SIHC Shining STARS or if we could use some improvement. *Southern Indian Health Council, Inc. is committed to always provide the highest care and satisfaction possible through high service standards and striving for continual improvement*. Please note that filling out this form will not compromise access to care.

Employee Involved: _____ Department Involved: _____

Date of Occurrence: ____/____/_____ Time of Occurrence: ____:____ ❑AM ❑PM

Describe event - include location, individual(s) who witnessed occurrence (if more than above) in as much detail as possible:

_____

_____

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_____

❑ I would like a response. ❑ I do not need a response.

_____ ____/____/_____

Name (first, last) (print) Date

Phone Number: (____) ____-_____

**Southern Indian Health Council, Inc. Use Only:**

Received By: _____ Received On: ___/___/____

Quality Management: _____ Received On: ___/___/____

Response Sent: ❑Yes Date: ____/____/_____

Approval Date: pending
Revision Date: 01.15.2019
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