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: ____/____/______