The Richland Hospital, Inc.

Muscoda Health Center
Spring Green Medical Center
Divisions of The Richland Hospital, Inc.

Patient Concern /Compliment Form

Patient _____ Date of Birth _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

Department _____ Physician _____

Clinic _____ Date(s) of Service _____

CONCERN / COMPLIMENT:

_____

_____

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_____

(Additional space available on other side)

If you have a concern, have you spoken to anyone at the hospital or clinic about it? ☐ Yes ☐ No

If yes, who did you speak with? _____

Date _____ Signature _____

www.richlandhospital.com

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