THE RICHLAND HOSPITAL
and Clinics

PATIENT CONCERN /COMPLIMENT FORM

Patient name:_____ Date of birth:_____

Street address: _____Phone:_____

City:_____ State: _____Zip:_____

Department:_____Physician:_____

Clinic: _____Date(s) of service:_____

Concern/Compliment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(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? _____

Signature: _____Date:_____

Please complete and mail to The Richland Hospital and Clinics, Community Relations, 333 East Second Street, Richland Center, WI 53581

The Richland Hospital and Clinics
333 East Second Street
Richland Center, WI 53581
608.647.6321 or 888.467.7485

Muscoda Health Center
1075 North Wisconsin Avenue
PO Box 657, Muscoda, WI 53573
608.739.3113

Spring Green Medical Center
150 East Jefferson Street
PO Box 10, Spring Green, WI 53588
608.588.7413