

**William Bee Ririe Hospital & Clinic**  
Patient/Visitor Concern Form

Person submitting concern: \_\_\_\_\_

Date of Concern: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Received by WBRH Staff: \_\_\_\_\_ Date Received: \_\_\_\_\_

Patient/Visitor Statement of Concern (use additional pages, if needed):

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Patient/Visitor's Recommendation(s) for improvement:

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Please return to: William Bee Ririe Hospital  
Public Relations Director  
1500 Avenue H  
Ely, Nevada 89301

Manager(s) Responsibilities:

Root Cause Analysis: \_\_\_\_\_

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Action taken (System/Process Improvements) – Attach a Copy of the Revised Policy & Procedure:

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Dept. Manager or Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Follow up Date: \_\_\_\_\_

Patient Follow-Up Method:  Letter  Phone  Other \_\_\_\_\_

Please forward this completed form on to the Public Relations Director and include any documentation appropriate to the investigation, recommendations, or conclusions provided.

Public Relations Director signature: \_\_\_\_\_ Review Date: \_\_\_\_\_

Resolution (Circle):  Satisfactory or  Unsatisfactory – If Unsatisfactory, explain:

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Did Patient forward on to Grievance Process:  Yes  No