Equitas Health Pharmacy

Customer Complaint Form

Customer Name:		**Date of Birth:**
Address:		
City:	**State:**	**Zip:**
Phone Number:	**Best Time To Contact (Circle One):** Morning Afternoon Evening	
Email Address:		
Date of Complaint:	**Employee(s) Involved:**	
Description of Complaint: (Please continue on back, if needed)		

For Office Use Only:

Date Received:	**Assigned To:**
Resolution Description: (Please continue on back, if needed)	
Date of Resolution:	**Date Patient Notified:**
Further Action Required? YES NO	**Signed:**