Northfield Hospital + Clinics

# Patient Grievance Form

**Description of Grievance:**

Name of person initiating grievance: _____

Relationship to patient: _____

Address: _____

Phone number: _____

Patient's name: _____

Date of birth: _____ Date of service: _____

**Description of issue or problem:**

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**An acceptable outcome would be:**

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When form is complete email to: patientadvocate@northfieldhospital.org or

mail to: Patient Advocate • 2000 North Avenue, Northfield MN 55057 • 507-646-1509