PHYSICAL THERAPIST ASSISTANT PROGRAM COMPLAINT FORM

Name of Person
Filing Complaint: _____ Date: _____

Complaint received: ☐ via phone ☐ in person (location)_____
☐ via email ☐ other (specify) _____

Complaint Origin: ☐ Clinical Site ☐ Public ☐ FVCC employee
☐ employer ☐ Student ☐other

Contact Info:

_____ _____
Phone Email Address

Description of Complaint:

Resolution:

Follow-up:

Received by: Date: