MONTGOMERY COUNTY FIRE AND RESCUE
EMERGENCY MEDICAL SERVICES
QUALITY ASSURANCE / QUALITY IMPROVEMENT

Healthcare Facility Concern Form

Facility Name_____ **Date**_____

Person Making Complaint_____

Incident #_____ **Units on Scene**_____

Complaint:_____
_____
_____
_____

Please forward to the QA Office when completed

---------- Below to be filled out by Quality Assurance Office----------

Date Received_____ **Reviewed By**_____

Date Complainant Interviewed_____ **QAI-SNF #**_____

Date Facility Interviewed_____

Findings:_____
_____
_____

Health & Human Services: **Information Purpose's only** _____
Complaint _____