HEALTH FACILITY PROGRAM COMPLAINT INTAKE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 61954 (2-2021)

Name of Person Submitting Form (Last, First)			
Address	City	State	ZIP Code
Email Address	Telephone Number (include area code)		
Name of Resident/Patient	Relationship to Resident/Patient		
Name of Facility (required)	Location of Facility (required)		
Type of Health Care Facility (example: LTC, Hospital, Basic Care)			
Describe Complaint or Concern (give as much detail as possible including names, dates and times) (required)			
Describe Action Taken Regarding this Complaint or Concern (if any)			

Mail to:
North Dakota Department of Health
Division of Health Facilities
1720 Burlington Drive
Bismarck ND 58504