Pharmacy Customer Complaint Form

Lower Lights Health
Specialty Pharmacy Services

Customer Name:	Date of Birth:

Address:

City:	State:	Zip:

Phone number:

Best Time for Us to Contact You (Check One): ☐ Morning ☐ Afternoon ☐ Evening

Date of Complaint:	Employee(s) Involved:

Description of Complaint: *(Please continue on the back if needed)*

FOR OFFICE USE ONLY:

Date Received:	Assigned to:

Resolution Description: *(Please continue on the back if needed)*

Date of Resolution:	Date Patient Notified:
Further Action Required? ☐ YES ☐ NO	Signed: