Office of the Medical Examiner

Spokane County
WASHINGTON

COMPLAINT TRACKING FORM

Complainant information

Complainant name		Address	
E-mail Address		Phone Number	
Preferred Contact Method	☐ Phone ☐ E-mail ☐ US Mail		
Complaint Date	[Complaint Date]	Resolution Date	[Resolution Date]

Does the complaint relate to activities / documents that are the responsibility of the Medical Examiner? ☐ Yes ☐ No

If no – transferred complaint and contact information to appropriate agency. [Agency] [Date Transferred]

Action Items

Action item	Date	Outcome
Acknowledged Complaint via ☐ Phone ☐ E-mail ☐ US Mail	[Date]	[Outcome]
[Action Item]	[Date]	[Outcome]
[Action Item]	[Date]	[Outcome]
[Action Item]	[Date]	[Outcome]
[Action Item]	[Date]	[Outcome]
[Action Item]	[Date]	[Outcome]

Accomplishments

[Accomplishments]

Concerns

[Concerns]

Conclusions

[Conclusions]

Final Resolution Date	[Resolution Date]

Signature	Date