

NWF Health Network

COMPLAINT RESOLUTION APPEAL FORM WRITTEN STATEMENT

Name (Print): _____

Date: _____

Department: _____

Supervisor's Name: _____

Telephone: _____

SUMMARY OF ATTEMPTS TO RESOLVE THE PROBLEM

Please indicate when you first discussed this with your supervisor: (Date, Time & Place)

Please briefly summarize your supervisor's response:

Please briefly summarize why you disagree with this response:

Date

Employee Signature

Please attach a copy of BBCBC Form 1100-1102 x1 Initial Complaint Resolution Form to this form.

NWF Health Network

**FOR ADMINISTRATION USE ONLY
SUMMARY OF RESPONSES FOR EACH LEVEL OF APPEAL**

I. Supervisor's Response (if applicable)

Name

Date

Signature

II. Chief Executive Officer's Response (if applicable)

Name

Date

Signature

III. Final Decision

Approved by:

Name & Title

Date

Signature

Acknowledgement:

I acknowledge that I have been notified of the final decision.

Date

Employee Signature