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