PATIENT/VISITOR COMPLIMENT FORM

Date_____________ Time_____________

Print Name of Patient or Visitor with Compliment

________________________________________ (_____) _______________________
Patient/Visitor Address Telephone Number

Please describe the compliment and include any pertinent information (names, titles, department, etc.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Please attach additional pages as needed).

Patient/Visitor Signature: X ___________________________ Date:_____________

If this form was written on behalf of the patient/visitor please sign below:

Signature: X ___________________________ Date:_____________

Relationship to Patient: ___________________________

The completed form will be forwarded to Patient Relations. Patient Relations can be reached at (845) 568-2300. A copy of the compliment will be sent to the management/staff/departments mentioned. Thank you.