TE MARAE ORA
COOK ISLANDS Ministry of Health

Formal complaint form

Name of complainant: ____

Address: ____

Phone: ____

Where did the problem occur?

Rarotonga Hospital   Tupapa Primary Health Care   Main Office Tupapa   Dental   Puna/Clinic
Other (Please specify): ____

Nature of complaint: ____

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Name(s) of staff involved: ____

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Were there any witnesses? If so, please list their name(s) and phone number: _______________________

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Did our staff attempt to correct the problem or resolve the situation when it occurred?   Yes   No

I understand that by signing this formal complaint form, I request that Te Marae Ora Ministry of Health will investigate my complaint. I will provide any and all information and cooperate in helping Te Marae Ora Ministry of Health resolve my complaint. The information I have and will provide is true and accurate.

Signature of complainant: ___________________________________   Date: ________________