Center for Justice Social Work
Soundview Wellness
P/F: 360.218.4645

GRIEVANCE/COMPLAINT FORM

First and Last Name: _____

Phone Number: _____ Email: _____

INFORMATION ABOUT YOUR CONCERN

Location of concerning incident: _____

Date concern occurred: _____

Approximate time that concern occurred: _____

Names of those involved :_____

Description of concerning incident: _____

_____

_____

_____

Is this your first time bringing up this concern? ☐ Yes ☐ No

Do you have any suggestions for resolving this concern? If so, please explain.

_____

_____

_____

_____ _____

Signature Date