Compliment Form

Date: _____

Patient Information

Name: _____

Contact Number: _____

Date of Service: _____

Facility:

☐ Dilkon ☐ Leupp ☐ Winslow

Department: _____

Staff: _____

Please provide us with details on the great service you received:

Submit to Patient.Advocate@wihcc.org or in person

Quality Management Department Use Only

Date Received: _____ Tracking #:_____

SUPERVISOR Notified on: _____