Marshfield Clinic
Health System

Medical Care Formal Grievance Request

Marshfield Clinic Health System (MCHS) values the opportunity to learn from patients and address all concerns. This form is used to file a formal complaint or grievance with MCHS for care received in hospital or clinical settings.

Name of patient ______________________________ Date of birth (m/d/y) ________ /________ /________

Facility and department name ______________________________ Date of service (m/d/y) ________ /________ /________

Medical history number (if known) ______________________________ Phone ______________________________

If you are not the patient, your name and relationship to patient ______________________________

Reason(s) for grievance: ______________________________

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Resolution or desired outcome sought: ______________________________

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Signature ______________________________ Date (m/d/y) _____ /_____ /_____

Note: *Grievances are not required to be in written form. Grievances can also be submitted verbally by calling the Patient Experience department and stating the intention to file a grievance when sharing the concern.*

Send completed form to:

Patient Experience Liaison
Marshfield Clinic Health System
1000 N. Oak Avenue
Marshfield, WI 54449

Email to: patient.experience@marshfieldclinic.org

Or call the Patient Experience Team: 715-387-5300

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