ADDICTION TREATMENT CENTER OF NEW ENGLAND

Addiction Treatment Center of New England Grievance Form

Name of Person Filing Grievance: _____

Client ID # (If applicable): _____ Phone or Contact Info: _____

Date Incident Occurred: _____

Description of events (attach a separate piece of paper if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any witnesses to the event:

_____ _____

_____ _____

What steps would you like to see happen to resolve this matter?

_____

_____

_____

_____

_____

_____

_____

Please submit this form to your Clinician or Clinical Director