

**Upham's Corner Health Committee, Inc.
d/b/a/ Upham's Elder Service Plan**

PARTICIPANT GRIEVANCE FORM

Participant information

PARTICIPANT NAME	PHONE
MEDICAL RECORD NUMBER	UESP CENTER

Grievance information

TODAY'S DATE	DATE OF GRIEVANCE
LOCATION/DEPARTMENT WHERE GRIEVANCE OCCURRED	
PERSON REPORTING GRIEVANCE (IF NOT PARTICIPANT)	
STAFF PERSON RECEIVING GRIEVANCE	UESP DEPARTMENT

GRIEVANCE MADE: in person via telephone other(specify):

GRIEVANCE DESCRIPTION (ATTACH ADDITIONAL PAGES IF NEEDED)

ACTION(S) REQUESTED BY PARTICIPANT

I understand that the Upham's Corner Health Committee will contact me within thirty (30) days to provide a report regarding the resolution of this grievance. If I am dissatisfied with the resolution of this grievance, I may appeal to the Executive Director.

Participant or delegate's signature Date signed

