ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Office of the Patient Experience
1001 Potrero Avenue, Building 25, H1246
San Francisco, CA 94110
Phone (628) 206-5176
Fax (628) 206-8878
E-mail: dph-patientexperience@sfdph.org

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

Office of Patient Experience Grievance Procedure

Zuckerberg San Francisco General Hospital wants to provide you with quality health care in a respectful, compassionate manner. If we did not meet your expectations during your stay or visit, we want to hear about it.

Q: Who can submit a grievance?

A: Any patient/visitor may file or communicate a concern/grievance regarding their treatment. If you are unable to file or communicate a concern/grievance, a family member, spouse, or significant other may file a concern on your behalf.

Q: What happens after submitting a grievance/concern in writing?

A: Below is the concern process:

1) Our office will send an acknowledgement/confirmation that we have received your concern.
2) We will reach out to the department where the concern occurred.
3) The department lead will be reaching out to you via phone to learn more about your experience.
4) The department lead will conduct an investigation of the occurrence and provide you with response of the outcome within 30 business days.

If you have any questions, feel free to contact our office at:

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PATIENT EXPERIENCE STATEMENT

Please submit completed form in person, by mail, fax or email to the Office of Patient Experience.

Today's Date: _____

PART I. PATIENT INFORMATION

Patient's First Name: _____ Last Name:_____

Date of Birth: _____ Medical Record #: _____

Address:_____
Street

_____
City State Zip Code

Telephone: ( ) _____ Okay to leave a message? ☐ Yes ☐ No

Name of your usual/primary doctor/ nurse practitioner: _____

Primary Care Clinic/Location: _____

PART II. STATEMENT *(This form is for Grievances and Compliments)*

Date of Occurrence: _____

Time of Occurrence: _____

Location(s)/ department(s) involved:_____

SUMMARY OF WHAT HAPPENED: Please include names and/or position of staff involved, if known: _____

_____

_____

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Please add more pages as needed

PART III. RESOLUTION

Please tell us the best way to reach you should we need more information:

☐ WRITE TO ME ☐ CALL ME ☐ I WILL CALL YOU ☐ EMAIL ME

SIGNATURE OF PATIENT:

_____

NAME OF ☐ SPOUSE ☐ FAMILY MEMBER ☐ VISITOR WRITING STATEMENT**:**

_____

_____

Address City Zip Code Phone/email

NAME/ TITLE/ PHONE # OF STAFF PERSON WRITING STATEMENT:

_____

THANK YOU FOR TAKING THE TIME TO TELL US ABOUT YOUR EXPERIENCE.

All grievances will be investigated and we will provide you with an update within 30 business days.