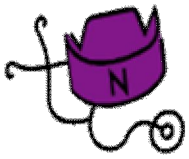

Compassionate Care Home Care Service, Inc.

Company Complaint

Date Received: _____

Complaint filed by:

Name: _____

Address: _____

_____

_____

Telephone: _____ E: mail _____

Is the individual filing the complaint a patient: _____ Yes _____ No

If not: Patient name: _____

Relationship to patient: _____

Complaint description including persons involved, and date(s) of incident(s):

_____

_____

_____

Follow up and disposition: _____

_____

Date complaint closed: _____ was the complainant satisfied? ___ Yes ___ No

If "No" explain _____

_____

Person responsible for handling the complaint:

Name: _____ Title: _____

PLEASE FAX ALL COMPLAINTS TO: (313)836-1852