CENTRAL INTERIOR
NATIVE HEALTH SOCIETY

FEEDBACK FORM

Please tell us about your experience.
We value your feedback.

What would you like to do? ○ Give a compliment ○ Make a comment / suggestion ○ Make a complaint

Your details	**Name**	**Contact Number**	**Email**

Do you need assistance to fill this form? ❑ yes ❑ no

I am a *(choose one):* ○ Client / Patient ○ Visitor ○ Family member ○ Other _____

Your Feedback

We would like to hear about your experience. Please tell us what happened and provide as much details as possible.

Date & Time _____ **Where** *(which area of CINHS)*

What happened?

What would you like to see happen as a result of your feedback?

SUBMIT

Complete this from and either:

1) Place it in the suggestion box located at the front desk 2) Hand it to the Patient Liaison 3) Email to client.support@cinhs.org