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| Western State HospitalStaunton, Virginia |
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| Complaint Resolution Form *(Formulario de Resolución de Quejas)* |
| **TO BE COMPLETED BY Individual Making Complaint (with help from staff if necessary)***Para ser llenado por persona haciendo la queja (con ayuda del personal si es necesario)* |

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| Name: *(Nombre)* |       | Date: *(Fecha)* |       | Ward*(Área)* |       |

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| Please explain the right you believe is being violated: (Use the Back if Necessary) *Explicar el derecho que cree que está siendo violentado: (Use el reverso si es necesario)* |
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| **To be completed by the WARD CLERK (*Para ser llenado por el ENCARGADO DEL ÁREA)*** |
| Date Received: |       | Date Submitted to Treatment Team  |       |
| *(Fecha de recepción)* |  | *Fecha presentado al equipo de tratamiento* |  |
| Signature of Ward Clerk *(firma del encargado del área)* |  |

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| **TO BE COMPLETED BY THE TREATMENT TEAM (*Para ser llenado por el EQUIPO DE TRATAMIENTO)*** |
| Describe the actions taken for resolution *(Describir las medidas adoptadas para la resolución):* |
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| Issue Resolved to Consumer’s Satisfaction? *¿El asunto fue resuelto a satisfacción del consumidor?* | [ ]  Yes *(Sí)* [ ]  No |
| Date Report Submitted to Hospital Director: |       | Signature: |  |

*Fecha informe presentado al Director del Hospital (Firma)*

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| **To be completed by the HOSPITAL DIRECTOR *(Para ser llenado por el DIRECTOR DEL HOSPITAL)*** |
| Date Received:*(Fecha de recepción)* |       |  |
| Director’s Actions: | *(Acciones del Director):* |
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| Issue Resolved to Consumer’s Satisfaction?*¿El asunto fue resuelto a satisfacción del consumidor?* | [ ]  Yes *(Sí)* [ ]  No |
| Date Referred to Facility Advocate: |        | *(Fecha referido al defensor de la Instalación)* |
| Additional Comments: | *(Comentarios adicionales):* |
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