Vivo Health Pharmacy Complaint Form

Customer Name: _____ Date: _____

Address: _____

Phone: _____ Email address: _____

Contact Preference: Phone _____ Email _____ Best time to contact you: _____

Complaint: _____

_____

Company representative receiving complaint: _____ Date: _____

RESOLUTION ACTIONS: **Response required within three business days**

Manager name: _____ Date of written response or call: _____

Problems or questions reported by customer: _____

_____

_____

Were problems or questions resolved: ____Yes ____No Other: _____

If resolved, explain how: _____

_____

If unresolved, explain next step : _____

_____

Signature of person completing form: _____ Date: _____

☐ Complaint forwarded to director /administration Date:_____

Director/administrator's name: _____ Date received: _____

Date customer contact made: Written: _____ Phone: _____ In Person: _____

How was complaint resolved? _____

_____

Director/administrator's signature: _____ Date: _____

Please email to our Vivo Health consumer advocacy representative at: **advocacy@vivohealthpharmacy.com**