



COMPLAINT REPORT FORM

Your name: _____

Address: _____

Phone number: _____

Do not fill out the above section if you wish to remain anonymous. Should you choose this option, you will not receive a response from the MAWS QMP Committee.

Please check this box if you wish to have your name withheld from all persons involved in the review process.

Name of midwife involved: _____

Date the incident occurred: _____

Your relationship to the mother and/or baby this incident involved: _____

Please describe the nature of your complaint:

Other information you feel is important:

A response will be sent to you within 14 business days of receipt. Please mail this form to:

MAWS QMP Committee
PMB 2246
10002 Aurora Ave N #36
Seattle, WA 98133-9348