THE INSTITUTE OF ALLIED HEALTHCARE

Student Complaint Form

Complete and turn in to Student Services

Full name: _____
Last First Middle

Mailing Address: _____
PO Box/Street City State Zip

Email Address: _____

Cell Phone #: _____ Home Phone #: _____

Student ID # _____

Describe your complaint in detail. Include any pertinent dates, locations, staff or faculty you dealt with, and any other relevant information. Be as specific and thorough as possible.

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

~ ~ ~ ~ Office Use Only ~ ~ ~ ~

Received by _____ on _____ Forwarded to _____ on _____

Results _____

Advanced to _____ on _____

Results _____