

COMPLAINT FORM

DATE: _____ TIME: _____
NAME: _____
ADDRESS: _____
TELEPHONE: _____ EMAIL: _____
NATURE OF COMPLAINT (Describe fully)
PERSON(S) INVOLVED:
LOCATION:
SIGNATURE

Please submit this complaint by mail to,

Progressive Care Network Complaint Department
8930 Bash Street, Suite G
Indianapolis, IN 46256

Or by fax to,

(317) 596-2809

Or by email to,

ehall@progressivecarenetwork.com

If you have additional questions please feel free to call us at,

(317) 596-2805
1-800-921-6496 Toll-Free