

Resident Concern Form
(To be completed by the Resident only)
Please Print Legibly

Name: _____

Home Phone: _____

Pager Number: _____

Program: _____

Complaint: *(Please use an attachment if the space provided is not adequate.)*

Resident Physician Signature and date

This form is to be returned to the Office of Graduate Medical Education at the below address:

Office of Graduate Medical Education
c/o Ravi Kallur
School of Medicine Room M1-212
2411 Holmes Street
Kansas City, MO 64108

Office Use Only

How Complaint Addressed:

Complaint Resolved Yes___ No___

Reviewed at Council on GME Meeting? Yes___ Date: _____ No___