Quality Management Program
COMPLAINT 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 Quality Management Program Committee.

❑ Please check here if you wish to have your name withheld from all persons involved in the review process, including the midwife named below.

Name of midwife (midwives) involved: ____

Date the incident occurred: ____

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

Please describe the nature of your complaint:

The QMP monitors specific sentinel events. Was there a sentinel event involved? If so, please check the appropriate event:

- ☐ Maternal mortality
- ☐ Perinatal mortality
- ☐ Maternal shock
- ☐ Uterine rupture
- ☐ Uterine inversion
- ☐ Maternal/neonatal seizure
- ☐ NICU or special care nursery admissions within 72 hours of birth (except for observation/congenital anomalies)

Other information you feel is important:

Please mail this form to:
If you do not receive an acknowledgement in approximately one month from the time you send it, please contact the QMP (qmp@washingtonmidwives.org). We recommend confirming the current MAWS address in order to prevent mail delays (http://washingtonmidwives.org/contact-maws.html).

MAWS attn QMP
2120 N Oakes St
Tacoma WA 98406

Thank you!
QMP Committee Members