AASM Accreditation Complaint Form

Please complete this form in its entirety. Forms received without complainant contact information will not be acted upon.

The AASM does not have investigative authority over licensed physicians, sleep centers, or their employees. The AASM does have the ability to review all complaints and can request information from either a member or the director of an AASM accredited facility related to the complaint. Members and facility directors are only required to provide information as it relates to AASM policy or the *Standards for Accreditation*. Issues unrelated to policy or standards of accreditation cannot be reviewed. In the event such complaints are received, the complainant will be directed to the appropriate oversight organization.

Section I: Complainant Information

First:____________________ Last:____________________ Credentials:________________________________

Address:____

City:____ State:__________ Zip Code:__________________

Phone Number:____ ☐ Home ☐ Cell ☐ Work

Email:____

I am a(n) ___________ of the sleep facility:

☐ Employee ☐ Patient ☐ Competitor ☐ Other:________________________________

Section II: Sleep Facility Information

Facility Name:____

Medical Director:____

Contact Person (if different):____

Address:____

City:____ State:__________ Zip Code:__________________

Phone Number:____

Email:____

Is this facility accredited by the AASM? ☐ Yes ☐ No

Section III: Complaint

Brief Description of Complaint (If possible, please list which AASM accreditation standards you believe have been violated. Standards may be reviewed at http://www.aasmnet.org/AccredStandards.aspx):

Please explain how you have previously attempted to resolve this complaint:______________________________

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I attest that the information submitted above is true and complete to the best of my knowledge. Further, I understand that upon submitting this complaint to the AASM, I am agreeing to be contacted regarding the matter. I also understand that although the AASM will make a good faith effort to keep my complaint anonymous, some circumstances require that information be shared with the sleep facility. I understand that in such instances the AASM will contact me prior to sharing my name or other identifying information. AASM policy prohibits accredited facilities from taking retaliatory actions against employees who report standards violations.

*Signature:*____ *Date:*______________________

Please fax or mail this form to:

The American Academy of Sleep Medicine,
Attention: Accreditation Department
2510 North Frontage Road
Darien, IL 60561. Fax: 630-737-9790