



## Customer Complaint form

Complainant/Distributor Information:			
Name of Complainant:		Contact Person:	
Clinic Name:		Phone No.:	
E-mail:		Address:	
Country:			
Hospital/Distributor Name:			
Product information:			
Device name:		Serial /Lot No.:	
Accessory:			
<input type="checkbox"/> IP	<input type="checkbox"/> SP	<input type="checkbox"/> RP	<input type="checkbox"/> SK <input type="checkbox"/> AN <input type="checkbox"/> BNC <input type="checkbox"/> CA
Serial /Lot No.:			
Description of the event:			
Event date:			
Patient affected:	YES <input type="checkbox"/> NO <input type="checkbox"/> , if YES please provide the information in below textbox.		
The product will be returned	<input type="checkbox"/>	The product will not be returned	<input type="checkbox"/> Comment:
Date:	Signature:		

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