Customer Complaint form

Complaintant/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:			
☐ IP ☐ SP ☐ RP ☐ SK ☐ AN ☐ BNC ☐ CA			
Serial /Lot No.:			
Description of the event:			
Event date:			
Patient affected:	YES ☐ NO ☐ , if YES please provide the information in below textbox.		
The product will be returned	☐	The product will not be returned	☐ Comment:
Date:	Signature:		

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