

**CROSSLEY STREET SURGERY
COMPLAINT FORM**

Complainants Details

Name:

Address:
.....

Contact Telephone Number:

Patient Details (if different from above):

Name:

Address:
.....

Date of Birth

Contact Telephone Number:

Full Details of Complaint

Date: Time:

Place:

Full description of events (i.e. the facts and surrounding circumstances giving rise to your complaint, please include the identity of any members of staff known to have been involved, if relevant). Please feel free to attach a separate sheet with these details if there is insufficient space provided:

Complainants Signature Date

Where the complainant is not the patient please complete the following: -

I hereby authorise the above complaint to be made and I agree that members of the practice may disclose (in so far as is necessary to do so to answer the complaint) confidential information about me with which I have provided them.

Patients signature Date