Thornfield Medical Group

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Partners :Dr NA Crowe, Dr RP Gray, Dr I D Jackson, Dr C Watson, Mrs T Stuchlik

Complaint form

Complainants Details:

Name _____
Address _____
_____
Telephone No _____
Date of Birth _____

Patient details (where different from above)

Name _____
Address _____
_____
Telephone No _____
Date of Birth _____

Complaint against:
Name _____

Date of incident _____
Time of Incident _____
Place of incident _____
Names of staff involved _____

Complainants signature _____Date _____

Full description of events (i.e. facts and other circumstances giving rise to your complaint)

Where the complaint is not the patient the following should be completed

I _____of _____
Hereby authorise_____ to make a complaint on my behalf and I agree that the members of the practice staff may disclose (in so far as it is necessary to answer the complaint) confidential information about me which I have previously provided.

Patient Signature:_____Date_____

FOR PRACTICE USE ONLY

Date received _____

Received by _____