

NAME & ADDRESS OF BLOOD BANK

Licence No.:-

SUGGESTION/COMPLAINT
FORM (GD-2)



Name (Optional):

Address:

Phone No:

Mobile:

E-mail:

Suggestion/Complaint details :

Date:

Signature

Patient / Donor ID
No:

Visit Date:

Report Date:

Referring Doctor: (IN CASE OF PATIENT / REPLACEMENT DONOR)

Remarks:

Complaint Reviewed By:

Date:

Corrective Action taken/proposed:

Feedback given back: