BMSG	COMPLAINT FORM

Complainant:			Complaint Number
Address:			
Telephone:	Fax:	e-mail	Receipt Date
Medical Professional:			

COMPLAINT DESCRIPTION / NATURE OF THE PROBLEM

Completed By: Date:

ROOT CAUSE ANALYSIS / INVESTIGATION RESULTS

❒ *Valid* ❒ *Non-Valid*

Completed By: Date:

CORRECTIONS / CORRECTIVE ACTIONS / PREVENTIVE ACTIONS

Action	Responsibility	Deadline	Status

Completed By: Date:

VERIFICATION OF CORRECTIONS / CORRECTIVE ACTIONS

Quality Assurance Manager: Date: