

ST ALBANS MEDICAL CENTRE

**212 Richmond Road, Kingston upon Thames, Surrey KT2 5HF**

**Tel: 020 8546 0400**

**Fax: 020 8974 5711**

**COMPLAINT FORM**

**Complainant’s details**

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| --- | --- | --- | --- |
| Name…………………………………………………………Date of Birth……………………………………….  Address…………………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………………..  Contact telephone number…………………………………………………………………………………….  E-mail address……………………………………………………………………………………………………….  **Patient details** (if different from above)  Name…………………………………………………………Date of birth………………………………………  Address…………………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………………..  **Summary of complaint (i.e. what is it that you most wish to complain about?)**   |  | | --- | |  |   **Full details of complaint**  Date…………………………………………………………………..Time……………………………………………  Place……………………………………………………………………………………………………………………….  Identify member(s) of practice…………………………………………………………………………….  Complainant’s signature……………………………………………………...Date………………………  **Full description of events** (i.e. the facts and surrounding circumstances giving rise to your complaint. You can provide this information in a separate letter if you prefer.   |  | | --- | |  |   **Where the complainant is not the patient (and appropriate consent is NOT held)**  I ………………………………………………………………….hereby authorise the above complaint to be made and I agree that members of the practice staff may disclose (in so far as it is necessary to do so to answer the complaint) confidential information about me which I provided to them.  Patient’s Signature…………………………………………………………………………Date………………………………….  **Please return completed forms to Milena Bodda, Practice Manager** |  |