Excellent Medical Center

PATIENT COMPLAINT FORM

Excellent Medical Center *is committed in providing a high-quality standard of care to all our patients. Should you wish to complain about a service you received from* ***Excellent Medical Center*** *kindly fill-up this form completely. Please be assured that your complaint will be kept confidential and shall be attended by the relevant personnel.*

COMPLAINANT INFORMATION: **بيانات المريض:**

Full Name:	**اسم المريض الثلاثي :**
Medical Record No.:	**رقم السجل الطبي :**
Home Phone No.:	**رقم هاتف المنزل :**
Mobile No.:	**رقم الهاتف المتحرك:**
Address:	**عنوان المريض :**

Complainant Information if other than patient: **بيانات مقدم الشكوى إذا لم يكن المريض مقدم الشكوى :**

Relationship:	**صلة القرابة :**
Patient Name:	

DESCRIPTION OF THE COMPLAINT: **الشكوى**

I hereby authorize the above complaint to be made and I agree that members of the ***Excellent Medical Center*** *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.*

T: +971 55 444 69 F: +971 55 446 59
Al Nasser properties, RB 2,
Mafraq Worker, City 2, Abu Dhabi - UAE

DOH Contact Number 800-555

www.emc-uae.com | info@emc-uae.com

Excellent Medical Center

Date: **التاريخ :**

Signature: **التوقيع :**

**********FOR MEDICAL CENTER USE ONLY**********

Complaint is received by: Name:_____ Position:_____ Date:_____

Complaint was referred to: Dept._____ Staff Name:_____ Date:_____

Please provide a description of the investigation performed regarding the complaint:

Name/Signature:_____ Date:_____

Please provide a description of the resolution provided:

Name/Signature:_____ Date:_____

Contacted the complainant? ❑ YES ❑ NO:_____

Complaint resolved? ❑ YES ❑ NO *(if NO please provide further details)*

Complaint Status: ❑ CLOSED ❑ PENDING

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Complaint Reviewed by:

_____ Date: _____
Admin Officer

_____ Date: _____
Quality Coordinator

_____ Date: _____
Medical Director

_____ Date: _____
General Manager

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