



Boland Bank Building, 5th Floor, Suite 501, 18 Lower Burg Street, Cape Town, 8000

Tel: (021) 426 4777

E-mail: tony@cpcqualicare.co.za

Website: www.docweb.co.za

PATIENT COMPLAINT FORM

1. Complainant Information

Full Name:	
Date of Birth:	
Phone Number:	
Email Address:	
Residential Address:	

CPC DOCTOR'S FUND (PTY) LTD T/A QUALICARE

Boland Bank Building, 5th Floor, Suite 501, 18 Lower Burg Street, Cape Town, 8000

Director: Dr AD Behrman

Reg No 95/03533/07 (Vat No 470175882)

2. Details of Complaint

Date of Incident:
Time of Incident:
Location / Department / Staff Involved:
Complaint Description:
(Please provide a detailed account of the incident, including what occurred and the individuals involved.)

3. Additional Information

Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide their names and contact details:
Have you reported this matter previously? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify when and to whom:

4. Expected Outcome

Please describe the resolution or action you wish to see as a result of this complaint:

5. Declaration

I hereby declare that the information provided in this form is accurate and truthful to the best of my knowledge.

Complainant Signature: _____

Date: _____

For Office Use Only

Received By:

Date Received:

Complaint Reference Number:

Acknowledgement Sent: Yes No

Investigation Conducted By:

Date Investigation Completed:

Outcome / Action Taken:

Date Complainant Notified:

Is Follow-up / Review Required? Yes No