

COMPLAINT FORM

Complainant's details

NameDate of birth.....

Address

E-mail address.....

Contact telephone number

Patient details (if different from above)

NameDate 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 only 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 Matthew Chilcott, Practice Manager.



*Clifton Road
Kingston upon Thames
KT2 6PG
Surrey
Tel: 020 3727 2230
Fax: 020 3727 2231
www.churchillmedicalcentre.com*



*Doctors:
Peter Smith OBE
Margaret Walker
Haythem Naseef
Adel Kartas
Bimal Raja
Lorraine Tite
Zoe Brown
Anita Indrakumar
Ida Tuck
Kashif Mazhar
Kirstie McQuattie
Io Epstein
Christopher Niranjan
Debasish Chatterjee
Kerry Giblin
Tanavi Patel
Elizabeth Rogers
Zabra Damji*

*Practice Manager:
Matthew Chilcott*

