COMPLAINT FORM

Please use BLOCK CAPITALS

Details of the Complainant	
Name	
Date of Birth	
Address	
Contact details (telephone/e-mail)	
Third Party Complaints (i.e. complaint on behalf of someone else) *Please note that if you wish to make a complaint on behalf of someone else, you must provide their permission in writing*	
Who are you complaining on behalf of?	
What is their date of birth?	
What is their address?	
What are their contact details?	
Details of your complaint	
Date complaint occurred	
Nature of complaint	

Nature of complaint (cont.)	
What outcome would you like to see from this complaint?	
I certify that the information given above is true:	
Print Name	
Signature	
Date	

Please return completed form to:
Complaints Officer, Saint John of God Hospital, Stillorgan, Co. Dublin, A94 FH92.
Tel: 01-277 1461 / E-mail: wecare@sjog.ie

FOR OFFICE USE ONLY:

Complaint No:	Month/Year:	Date Received:	Signature of Receiver: