Customer Complaints

Person Completing Form (name):	
Phone #:	Date Reported:

Contact Information

Contact Name:	Address:
Phone #:	
Email:	

Complaint Origination:

☐ **Donor** Name: Donor ID: Date of Birth:	☐ **Hospital/Client:** Facility: Department: Unit(s)#:
	☐ **Other, specify:**

IBR Location of Occurrence (if applicable): _____

Description of Occurrence _____

Customer Complaints

IBR Investigation and follow up, if applicable
To be completed by IBR Staff: _____

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Forwarded to (department): _____ Date: _____
Data Entry into MasterControl by (name and date):_____
MasterControl Customer Complaint Number: _____