|  |  |
| --- | --- |
| 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**

**IBR Investigation and follow up, if applicable**

**To be completed by IBR Staff:**

Forwarded to (department): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data Entry into MasterControl by (name and date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MasterControl Customer Complaint Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_