

ALLEGED FOOD POISONING

These forms are designed to collect information to facilitate any investigation, and do not imply the “de facto” legal responsibility of the SPAR Group LTD, SPAR stores, any of its employees or representative.

This form comprises of 3 sections, to be filled in by the Manager receiving the complaint, the client concerned and the Medical Practitioner attending the client.

All completed forms and/or correspondence must be returned/forwarded to the Retail Operations Manager and the Group Food Safety Manager contacted for referral to the appropriate laboratory.

All information must be treated in the strictest confidence and the dignity of the client be kept in mind at all times.

PART 1

TO BE COMPLETED BY THE STORE MANAGER

Name and surname of Client: _____

Physical Address: _____

Postal Address if different: _____

Telephone contact number: Work () _____ Fax () _____

Cell () _____

Date and Time of first report? _____

Till slip available ☐ Yes ☐ No Please attach original till slip or readable copy _____

SPAR Store Physical Address and Postal address: _____

Manager Name & Surname: _____

Tel () _____ Fax () _____

e-mail address (if any): _____

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PART 2A

TO BE COMPLETED BY THE CLIENT

Name & Surname: _____

Physical Home Address: _____

Date of Birth: _____

Do you suffer from any food allergy: _____

Are you under any medication? ☐ Yes ☐ No If yes, please specify _____

What food did you eat / liquid did you drink? _____

a) What symptoms did you experience? _____

b) How long after starting to consume the food/beverage did the symptoms appear? _____

What food and / or beverages did you consume before? _____

Where: Home ☐ Hotel ☐ Restaurant ☐ Fast Food outlet ☐ If other, please specify: _____

How many meals / beverages did you have before the symptoms appeared: (Viruses and bacteria incubation between 30 min and 72 hours)

Within the previous 12hours ☐ Where: _____ What food / beverages: _____

Within the previous 24hours ☐ Where: _____ What food / beverages: _____

Within the previous 36hours ☐ Where: _____ What food / beverages: _____

Within the previous 48hours ☐ Where: _____ What food / beverages: _____

Within the previous 60hours ☐ Where: _____ What food / beverages: _____

Within the previous 72hours ☐ Where: _____ What food / beverages: _____

Previous Food poisoning case if any: ☐ Yes ☐ No If yes, please specify _____

Family doctor's Name: _____ Address: _____

_____ Tel (): _____

Confidentiality and Disclaimer: These forms are completed on the express understanding that the information contained herein shall be regarded and treated as strictly confidential by all the respective parties. It is not to be delivered nor shall its contents be disclosed to anyone other than the SPAR Retailer, its employees, representatives, consultants and insurers. Moreover, it shall not be used, in whole or in part, for any purpose other than for the gathering of information to facilitate an investigation by the SPAR Group LTD into the food poisoning claim, or making an insurance claim. The customer shall not publicise the details of his/her complaint pending the completion of the investigation.

Finally, please note that the cooperation of The SPAR Group Ltd and the relevant SPAR Retailer in the investigation of the customer's complaint, does not constitute an admission of liability on their part.

Customer Name: _____ Signature: _____ Date: _____

Retailer Name: _____ Signature: _____ Date: _____

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PART 2B

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

Doctor's Name: _____

Contact Address: _____

Tel (): _____ Fax (): _____

Registration No.: _____

Hospital Name: _____

Contact Address: _____

Tel (): _____ Fax (): _____

Diagnosis: _____

Laboratory results in case of blood analysis: (*) _____

Laboratory results in case of stool analysis: (*) _____

Treatment: _____

Duration of hospitalization: _____

Duration of incapacity: _____

(*) Copies of laboratory results to be attached.

Doctor's Name: _____ Signature: _____ Date: _____