Biosite
MEDICAL INSTRUMENTS

PRODUCT COMPLAINT HANDLING FORM

REGULATORY DEPARTMENT

CUSTOMER CODE:_____

CUSTOMER INFORMATION			
CUSTOMER NAME		JOB TITLE	
HOSPITAL NAME		HOSPITAL ADDRESS	
PHONE NO.		FAX NO.	
EMAIL ADDRESS		COMPLAINT NO	

INCIDENT INFORMATION					
DESCRIPTION	PRODUCT CODE	DATE OF INCIDENT	PRODUCT (BATCH & LOT)	EXPIRY	PRODUCT SPECIFICATION/ SIZES

PROBLEM DESCRIPTION/ REPORT ATTACHMENT:

TO BE FILLED OUT BY BIOSITE MEDICAL INSTRUMENT

INITIAL RECOMMENDATION	FINAL RECOMMENDATION	Status of Complaint (check the appropriate parentheses) Please specify whom it was endorsed and action done:
		☐ RESOLVED ☐ ENDORSED ☐ OTHERS _____ REMARKS:

ISSUED BY	RECEIVED BY	APPROVED BY
(Signature over Printed Name) DATE SIGNED:	*(Signature over Printed Name)* DATE SIGNED:	*(Signature over Printed Name)* DATE SIGNED: