**STOKENCHURCH MEDICAL CENTRE**

Oxford Road Stokenchurch Bucks HP14 3SX Tel: 0844 5769633

**FORM 36.2**

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| **COMPLAINTS FORM** |
| **Complainant's Details** |
| Name |
| Address |
| Telephone No Home Work |
| **Patient's Details (if different from above)** |
| Name |
| Address |
| **Details of Complaint** |
| Date: .......................... Time: ........................ Place: ............................. |
| Nature of Complaint (Please use separate sheet if necessary): |
| ***Signed: ................................................................ Dated: .........................*** |
| If the complainant is not the patient, the patient should complete the section below to show that consent has been obtained:**I,** hereby authorise theabove complaint to be made and agree that members of Dr .................surgery may disclose (only in so far as it is necessary) confidential information about me to the complainant named above.**Signed: ………………………………………………… Dated:…………………..** |

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