doktersdienst groningen

Complaint form

Name: .....

Street address: .....

Zip code: ..... **City:** .....

Phone no.: .....

Patient's birthday: .....

Date of treatment:

Day: ..... **Date:** ..... **Time:** .....

The complaint:

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Continue on the other side

Date: ..... ***Signature:*** .....

Send this form to (a poststamp is not necessary):
Klachtenafdeling Doktersdienst Groningen
Antwoordnummer 463
9700 WB Groningen

doktersdienst groningen

Continuation of the complaint