

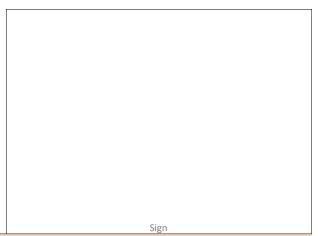
To: Administrative Services of GHA 'Laiko'

Date:

COMPLAINT FORM

| PERSONAL DETAILS | | | | | | |
|-----------------------|--|-------|--|--|--|--|
| Name-Surname: | | | | | | |
| Address: | | Tel.: | | | | |
| COMPLAINT DESCRIPTION | | | | | | |
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What do you suggest to resolve the issue:



COMPLAINT MANAGEMENT (To be completed by the Office for the Protection of the Rights of Health Recipients)

| Instructions for handling the Complaint by the competent Administrative Services: | | | | | | |
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| Hospital / Service Department (where the complaint is addressed to) | | | | | | |
| Complaint category: Medical Care: Information: Service: Other | | | | | | |
| View of the Head of the Department: | | | | | | |
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| Complaint handling or management: | | | | | | |
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| Was the complainant informed? | YES: | NO: | How: | |
|--|------|-----|------------------------|--|
| Was the complainant informed that the full management of his case may require more than 30 days? | YES: | NO: | lf NO, explain why: | |
| | | | | |
| Was the case processed within the predefined period of 50 days? | YES: | NO: | If NO, explain why: | |

Name of the Head of the Office for the Protection of the Rights of Health Recipients

Sign