

Gants Hill Medical Centre

COMPLAINT FORM

Patient Full Name: _____

Date of Birth: _____

Address: _____

Complaint details: (Include dates, times, and names of practice personnel, if known)

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SIGNED..... DATE:.....

Please hand the completed form to reception.

The complaint can also be sent to the following email, addressed to the Practice Manager:
gantshill.medicalcentre@nhs.net