|  |
| --- |
| Person Completing Form (name): |
| Phone #: | Date Reported: |

**Contact Information**

|  |  |
| --- | --- |
| Contact Name: | Address: |
| Phone #: |
| Email: |

**Complaint Origination:**

|  |  |
| --- | --- |
| [ ]  **Donor**Name: Donor ID:Date of Birth: | [ ]  **Hospital/Client:** Facility:Department:Unit(s)#:  |
| [ ]  **Other, specify:**  |

**IBR Location of Occurrence (if applicable):**

**Description of Occurrence**

**IBR Investigation and follow up, if applicable**

**To be completed by IBR Staff:**

Forwarded to (department): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data Entry into MasterControl by (name and date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MasterControl Customer Complaint Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_