Zorgsupport

Complaints/suggestions form for patients and visitors

You can also use the on-lineform on www.amsterdamumc.nl/nl/vragen-en-klachten.htm .

Personal data

Name	Date of birth	M/F/X
Address		
Postal Code, City		
Phonenumber (office hours)	Patient ID (MDN)	
E-mail		

Does your complaint/suggestion concern: ☐ location AMC ☐ location VUmc

☐ clinic/ward ☐ an out-patient clinic ☐ other

Please specify/describe which one:

Are you the patient involved? ☐ yes

☐ no, your name:_____

relationship to the patient: _____

telephone:_____

☐ not applicable

Following your report, an employee of the complaints department will contact you.
Please indicate a convenient time (business hours):

In order to handle your complaint we may need to access your medical record. Therefore we need your informed consent. If you do not want that, please tick this box: ☐

Please descibe your complaint/suggestion:

You can also use the other side of this form

Signature:_____ Date: _____

You can either drop of this form or submit it by post to the following address:

Amsterdam UMC	location AMC: afdeling Patiëntenservice Zorgsupport, A0-404
	location VUmc: afdeling Patientenservice Zorgsupport, PK 0 hal 08
Post:	Amsterdam UMC, t.a.v. klachtenfunctionaris/complaintsofficer
	Postbus 22660
	1100 DD Amsterdam
E-mail:	klachten@amsterdamumc.nl

Describe your complaint/suggestion – continue:

Registration by Patient Information Department

Received by: _____ Date: _____