

Dienst patiëntenzorg

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 describe 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 Dienst patiëntenzorg, A0-404
location VUmc: afdeling Patientenservice Dienst patiëntenzorg, 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: _____