



Product Complaints Report

Date: - / /20

This section to be filled with customer or company representative

1- Customer information

Name			
Address			
Telephone			
Contact person			
Receiving complain method	<input type="checkbox"/> Phone	<input type="checkbox"/> Writing	<input type="checkbox"/> Personal meeting
Name of receiving complains			

2- Product Information

Product Name	
Code Number	
Batch Number	
Lot Number	
Manufacture date	

3- Summary of complain

Complain effect on consumer health care	<input type="checkbox"/> Affect	<input type="checkbox"/> Not affect
Applying recall program decision	<input type="checkbox"/> Applied	<input type="checkbox"/> Not applied

This section to be filled with quality team

4- Following complain

Basic reason for complain:

Applied corrective action:

Complain solver Name		Department		Date	/ /20
----------------------	--	------------	--	------	-------

Follow up the CAR		Department	Quality Assurance	Date	/ /20
-------------------	--	------------	-------------------	------	-------

Remarks :



5- If the complaint invalid			
Justification			

Quality Assurance & regulatory affairs Director Sign.			Date / /20