

PRODUCT COMPLAINT FORM

CID No. : _____
(For office use)

Date: _____

Name of the patient / complainant: _____ Contact No. _____

Address: _____

Pincode: E-mail ID : _____

Patient Age _____, Height _____, Weight _____, Deformity _____,

Product Name _____, Model /Type _____, Side _____, Size _____, Serial.No. _____

Purchased by Invoice No. _____ Date: _____ from whom: _____

Nature of complaint as per Complainant : _____

Photo/Video of Defective product attached (PI tick) - **Yes / N**

Additional **For Prosthetic**: Amputation level _____, Fitment Date _____,

NM pressure Applied _____, Mobility Class _____, Activity level _____,

Expected time of solving the complaint: _____ **Additional** requirements (if any): _____

Sign of patient/complainant

Complaint forwarded by

Sign of PMIPL representative

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