PHARMAMAAC
THE HOLISTIC CHOICE

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COMPLAINT REPORT	
Title of complaint*	
Date of complaint*	
Name and surname*	
Address	
Telephone number*	
E-mail*	
To be filled in only by the health institution/pharmacy:	
Name of company/institution*	
Invoice number and date*	
Item name, valid until, batch, quantity	
Type of complaint	◯ Complaint about product turnover (wrong/quantity/product/validity date) ◯ Complaint about product quality ◯ Complaint about service/employee ◯ Other
Complaint description*	
To be filled in only by "Pharma-Maac"d.o.o.	
Complaint number	

Fields marked with * are required and all incoming complaints where all required fields are not filled in will be considered incomplete and will not be considered.