

Please submit this form to the Reception or send it by e-mail to: comunicazione@cnao.it

PATIENT NAME and SURNAME			DATE
SEX	AGE	NATIONALITY	EDUCATION
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ITALIAN <input type="checkbox"/> EUROPEAN <input type="checkbox"/> EXTRA-EUROPEAN	<input type="checkbox"/> NONE <input type="checkbox"/> COMPULSORY SCHOOL <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> DEGREE
E-MAIL ADDRESS		TELEPHONE NUMBER	

CLAIM DESCRIPTION (to be filled in by the person recording the claim)

<p>Date: _____ Signature: _____</p>

Your personal data will be processed for the sole purpose of dealing with your report and acknowledging its receipt. The information entered in the form will be kept for as long as necessary to deal with your request and it will be deleted within a year from the date of its forwarding in order to allow all necessary checks'.

ANALYSIS OF THE CAUSES GIVING RISE THE CLAIM	CORRECTIVE ACTION/ PREVENTIVE ACTION
<p>Date: _____ Signature: _____</p>	

ACTIONS FOR SOLVING THE CLAIM

ACTIVITIES	PERSON IN CHARGE	DEADLINE

Date: _____ Signature: _____

CLAIM SOLVING

<p>Date: _____ Signature: _____</p>

CLOSURE OF THE CLAIM TO BE VERIFIED BY THE PERSON IN CHARGE OF THE QUALITY MANAGEMENT SYSTEM

<p>AC/AP: _____ DATE: _____ SIGNATURE (QM): _____</p>