CNAO Centro Nazionale di Adroterapia Oncologica	**PATIENT CLAIM** N°:	Mod. 007 rev.7 Pag. 1 di 1

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**
☐ MALE ☐ FEMALE		☐ ITALIAN ☐ EUROPEAN ☐ EXTRA-EUROPEAN	☐NONE ☐COMPULSORY SCHOOL ☐HIGH SCHOOL ☐DEGREE
E-MAIL ADDRESS		**TELEPHONE NUMBER**	

CLAIM DESCRIPTION (to be filled in by the person recording the claim)	
Date:	**Signature:**

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 claim and it will 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
Date: **Signature:**	

ACTIONS FOR SOLVING THE CLAIM		
ACTIVITIES	PERSON IN CHARGE	DEADLINE
Date: **Signature:**		

CLAIM SOLVING
Date: **Signature:**

CLOSURE OF THE CLAIM TO BE VERIFIED BY THE PERSON IN CHARGE OF THE QUALITY MANAGEMENT SYSTEM		
AC/AP:	DATE:	SIGNATURE (QM):