

Zorgsupport

Complaints/suggestions form for patients and visitors

You can also use the on-lineform on www.amsterdamumc.nl/nl/vragen-en-klachten.htm .

Personal data				
Name		Date of birth	M/F/X	
Address				
Postal Code, City				
Phonenumber (office hours)		Patient ID (MDN)		
E-mail				
Does your complaint/suggestion concern:		□ location VUmc		
	🛛 clinic/ward 🔲 an out-pa	itient clinic 🛛 ot	her	
Please specify/describe which one:				
Are you the patient involved?	□ yes			
	🗆 no, your name:			
	relationship to the patient:			
	telephone:			
	not applicable			
Following your report, an emp Please indicate a convenient t	loyee of the complaints departme (business hours):	ent will contact you.		
In order to handle your complaint we may need to access your medical record. Therefore we				
need your informed consent. I	f you do not want that, please tio	k this box: \Box		

Please descibe your complaint/suggestion:

You can also use the other side of this form

Signature:_

You can either drop of this form or submit it by post to the following address:		
Amsterdam UMC	location AMC: afdeling Patiëntenservice Zorgsupport, A0-404	
	location VUmc: afdeling Patientenservice Zorgsupport, PK 0 hal 08	
Post:	Amsterdam UMC, t.a.v. klachtenfunctionaris/complaintsofficer	
	Postbus 22660	
	1100 DD Amsterdam	
E-mail:	<u>klachten@amsterdamumc.nl</u>	

Describe your complaint/suggestion - continue:

Registration by Patient Information Department Received by: _____ Date: _____