



TO BE COMPLETED BY THE COMPLAINANT
(OR BY DESIGNATED APPOINTEE IF THE COMPLAINANT IS INCAPACITATED)

DETAILS OF THE CUSTOMER

ID Card No. (if available): - - -

Health Insurance Card No.

Name (in full):

Address:

Tel. (landline): Tel. (mobile):

Date of birth: dd / mm / yyyy

Gender: Male

Female

NATURE OF COMPLAINT

General Concern

Health Insurance

Medical / Administrative Staff

Healthcare Provider

Private Healthcare

HAAD

Please specify

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SEHA

Quality

Medical Staff

Administrative Staff

Medical Malpractice

General

Other (please specify)

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