**TO: The National Manager**

 SESNZ

 PO Box 37415

 Christchurch 8245

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| SESNZ COMPLAINT FORM |
| DETAILS OF COMPLAINANT / REPRESENTATIVE |
| Title & Full names of complainant |  |
| Identity / Passport number  |  |
| Postal Address  |  |
| Physical Address  |  |
| Mobile number |  |
| Landline number  |  |
| Fax number  |  |
| E-mail address |  |
| Power of Attorney must be attached if complainant is a representative. |  |
| DETAILS OF THE CLIENT IF THE CLIENT IS NOT THE COMPLAINANT |
| Title & Full names of the patient |  |
| Identity number/birth date/Passport number |  |

|  |  |
| --- | --- |
| Postal Address |  |
| Physical Address  |  |
| Mobile number  |  |
| Landline number  |  |
| Fax number  |  |
| E-mail address  |  |
| DETAILS OF PRACTITIONER |
| Name of Practitioner |  |
| Physical Address (not PO Box)  |  |
| SESNZ Registration Number  |  |
| Practice Number (Allied Health) |  |
| Mobile number  |  |
| Telephone Number  |  |
| Fax Number  |  |
| E-mail address  |  |
| What outcome do you expect for this complaint?  |  |
| Date  |  |
| Place  |  |
| DETAILS OF COMPLAINT (or attach to this form) |
|  |
| Have you approached the member about this complaint?   |
| If yes, what was the outcome? (please attach if you need to) |
| Have you complained to another organisation about the same matter? |
| If yes, what was the outcome? (please attach if you need to) |
| Signature of complainant  |  |