**TO: The National Manager**

SESNZ

PO Box 37415

Christchurch 8245

|  |  |
| --- | --- |
| 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 | |  |