**№** ................ / .........................

(filled by the PT provider)

**FILLED BY THE CLAIMANT**

Regarding: ………………………………………………………………………………………………………...........…….…

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Claimant: ........................................................................................................................………

Address: …….........................................................................................................................

Telephone number: ...........……………………………….............................

Contact person: .......................……………..............................................................................

Description of the problem: ……………………………………..…...............……………………………………………

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………………………………………………………………………....………………………………………………………………

Date: …………..

FILLED BY THE PT PROVIDER

Claim, accepted by: ………………………….....................................................................……

/name and surname, signature/

Date: ....................................

Relevance of the claim: ………………………………………………………………………....................................

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Necessity of corrective/preventive actions: ................................................................................

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Opinion of the Quality Manager: ..................................................

/name and surname, signature/

Deadline:.................................. Responsible person: ..................................................

/name and surname, signature/

Efficiency of the measures taken: .................................................................................

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Manager of PT Provider UCLSB: ……………………………………………….

/name and surname, signature/

Date: ....................................