



INNOMED, INC.

INCIDENT REPORT / COMPLAINT FORM

IF-720-014

REPORT TYPE (choose one)	
<input type="checkbox"/>	INCIDENT REPORT
<input type="checkbox"/>	COMPLAINT

DATABASE TRANSACTION #	CLOSURE DATE

DATE OF INCIDENT	DATE REPORTED BY CUSTOMER	DATE RECEIVED BY INNOMED	DATE ENTERED TO DATABASE	
LOCATION OF INCIDENT	REPORTED BY (NAME)	INNOMED REP WHO RECEIVED	COMPLAINT TYPE	
			← IF OTHER, EXPLAIN	
CUSTOMER ACCOUNT #	CUSTOMER PO #	ORIGINAL INVOICE #	INVOICE REPLACEMENT #	
CUSTOMER / COMPANY NAME		COUNTRY		
CUSTOMER CONTACT NAME		PHONE 1		
ADDRESS		PHONE 2		
ADDRESS 2		EMAIL		
CITY		STATE	ZIP	
PRODUCT #	LOT #	DEVICE NAME		
NATURE & DETAILS OF COMPLAINT OR INCIDENT				
CORRECTIVE ACTION #	CORRECTIVE ACTION DUE DATE	STATUS OF COMPLAINT	FOLLOW UP DATE	MDR #
RESULTS OF INVESTIGATION				
COMMENTS				
REPLY TO COMPLAINT OR INCIDENT				