



Customer Complaint / Incident Form

Name of Facility: _____

Name of Surgeon: _____

Date of Complaint / Incident (dd/mm/yyyy) ____/____/____

Was the product being used in surgery at the time of the incident?

- Yes
- No

Was the procedure delayed?

- Yes
- No

Did the incident involve injury to the patient?

- Yes
- No

If "yes", please describe the injury here:

Were there any other devices being used with our device?

- Yes
- No

If "yes", please list the devices here:

Will the device be returned to GENICON?

- Yes
- No

Is a Vigilance/MDR report required?

- Yes
- No

Please describe the incident in as much detail as possible: