Bloomfield Health Services

Fundraising & Communications
Complaint Form

Your Details

Name _____

Address _____

_____

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_____

Phone _____

Email _____

Date of Complaint _____

Nature of the Complaint

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I confirm that the above information is correct.

Signed _____ Date_____

Please return to: Complaints Officer, Bloomfield Hospital, Stocking Lane, Rathfarnham, Dublin 16.

For Office Use

Complaint Ref	Month / Year	Date Received	Received by