

Product Quality Complaint Form

Product Quality Complaint Form						
Company name					Soma Pharma Suriname, version 1.01	
Name			Title	<input type="checkbox"/> Pharmacist <input type="checkbox"/> Director <input type="checkbox"/> Warehouse/Purchasing Department		
Adress			Phone		Email	
Date					<i>Signature</i>	
Complaint details						Units
Name and strength of product			Batch number		Exp date	
Manufacturer			Purchase date		Invoice number	
Date complaint received			Product complaint received from:		<input type="checkbox"/> Customer <input type="checkbox"/> Warehouse <input type="checkbox"/> Other, specify	
Product complaint details						
Primary Pack (bottle/blister)	<input type="checkbox"/> Damaged <input type="checkbox"/> Cap damaged <input type="checkbox"/> Punctured		<i>Describe your complaint or actions here :</i>			
Secondary pack	<input type="checkbox"/> Damaged <input type="checkbox"/> Leaflet missing					
Labeling	<input type="checkbox"/> Damaged <input type="checkbox"/> Information missing <input type="checkbox"/> Information wrong					
Product appearance	<input type="checkbox"/> Discolouration <input type="checkbox"/> Odour					
Tablets	<input type="checkbox"/> Damaged <input type="checkbox"/> Size <input type="checkbox"/> Pulverized					
Liquids	<input type="checkbox"/> Discolouration <input type="checkbox"/> Odour <input type="checkbox"/> Sediment <input type="checkbox"/> Taste					
Product sample available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Picture					
	<input type="checkbox"/> Sample attached for analysis					
Actions till date?	<input type="checkbox"/> Reimbursed <input type="checkbox"/> Inventory block					
For INTERNAL USE only			COMPLAINT PROCESSING			
Date received			by (full name)			
Actions	<input type="checkbox"/> Reimbursed <input type="checkbox"/> Inventory block <input type="checkbox"/> Send to Manufacturer					<i>Signature</i>
	<input type="checkbox"/> Local lab testing <input type="checkbox"/> Other					
	Other					
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