The Manitoba Pharmaceutical Association

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COMPLAINT REPORT
Filed with the Manitoba Pharmaceutical Association

PLEASE PRINT CLEARLY

COMPLAINANT**:** _____

ADDRESS: _____CITY _____ POSTAL CODE: _____

HOME PHONE NO.:_____ BUSINESS NO.:_____

BEST PLACE AND TIME TO CALL: _____

PHARMACY NAME AND ADDRESS: _____

PHARMACIST'S NAME (IF KNOWN):

COMPLAINT:

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(IF MORE SPACE IS REQUIRED PLEASE CONTINUE ON THE BACK)

WOULD YOU BE WILLING TO APPEAR BEFORE A COMMITTEE OF ENQUIRY IF REQUESTED? ___ YES ___ NO

COMPLAINANT'S SIGNATURE:_____ DATE:_____

PLEASE RETURN FORM TO THE MANITOBA PHARMACEUTICAL ASSOCIATION AT THE ABOVE ADDRESS, ATTENTION: THE REGISTRAR