BodyCurve

Confidence, On Your Terms

Complaint Form

Patient Full Name:	
Date of Birth:	
Address:	
Post Code:	
Contact Email Address:	
Contact Telephone Number:	

Complaint details: (please include as much information as possible including dates, times and names of people you have spoken to)

Patient signature:	
Print Name:	
Date:	

Please return this form via:
Email: patientrelations@bodycurve.co.uk
Post: BodyCurve 49 Piccadilly Manchester M1 2AP

Use this page for additional space: