

FEEDBACK PROVIDER DETAILS

Please complete this section with details of the originator of the feedback.

Feedback Received from: (select one)

Distributor Wholesaler Pharmacist Healthcare Professional Self-Test User

Individual and/or Company Name: _____

Email Address: _____

Phone No: _____ Country: _____

Date Reported: _____

How Reported: (select one) Phone Text Email Other _____

FEEDBACK DETAILS

Please provide as much information as possible and include supporting images or documentation, where appropriate.

Product Name: _____

Product Code: _____ Product Lot Number: _____

Date of Incident/Event being Described: _____

Description of Feedback: _____

THIS SECTION TO BE COMPLETED BY DISTRIBUTOR

Company Name: _____

Your Name: _____

Email Address: _____

Once form is completed e-mail to: feedback@atomodiagnostics.com

THIS SECTION TO BE COMPLETED BY ATOMO

Is Feedback Negative Positive If negative, was it an Incident Non-Incident PMS # _____

Justification for classification _____

Name _____ Position _____ Date _____