



CONSUMER COMPLAINT FORM

Name of Report		
A response letter on Corporate letter head is required to be sent to: _____ (Customer Service Specialist) LeeSar, Inc. 2727 Winkler Avenue Fort Myers, FL 33901 Vendors are to contact this person at this facility for more information on the complaint		
Date		Hospital:
Initiator		Phone Number:
Department		Department Number:
This is not for vendor use. These contacts are for Member Supply Chain Staff Only		
Supply Chain Contact(s)	Clinical Resource Manager: Clinical Resource Analyst: Please complete this form and email to: (Member to enter email information) (Click to check a square)	
Problem is	<input type="checkbox"/> Supply <input type="checkbox"/> Equipment <input type="checkbox"/> Other:	
Nature of Problem	<input type="checkbox"/> Defective <input type="checkbox"/> Safety Concern <input type="checkbox"/> Design Function <input checked="" type="checkbox"/> Mfg. Problem	
Physician Issue		
Location of Defective Products		
Origin of Report		Lot number:
Product description		Number of Occurrences:
Product Catalog #		
Mfg. by:		
Please give details. Be as specific as possible		
LeeSar Requirements	<input type="checkbox"/> Customer Service Assistance <input type="checkbox"/> Pack Ops Assistance Notes for Customer Service:	
Supply Chain Response Only	Date: _____ Date: _____ Date: _____ Date: _____	Determine Cause / Root Cause Analysis: Corrective action taken: Validate/verify corrective action is working by: Site Visit: Email Verification:
Vendor Response	Date: _____ Comments: _____ _____ _____	

~~Member affected?, Has vendor been contacted Y/N if Yes, Vendor Response? LSR customer service assistance, pack ops assistance? Notes for Customer Service, CS Follow up date~~