**HEE POSTGRADUATE MEDICAL AND DENTAL EDUCATION
 COMPLAINTS FORM**

|  |  |
| --- | --- |
| **Full Name** (Title, first name, surname) |  |
| **GMC/GDC Number** |  |
| **Address** |  |
| **Daytime telephone or mobile number** |  | **Email address** |  |
| **Specialty** (If applicable) |  |
| **Job Title** (i.e. ST1, if applicable) |  |
| **Brief description of complaint**(please include dates and supporting evidence, if applicable) |  |
| **What do you believe will resolve this complaint?** |  |

**Signed:**

**Dated:**

**Ref No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** *(for office use only)*