

Complaint Form

Please send the case to following address:

Dentsply Sirona Deutschland GmbH
 Complaint Department
 Fabrikstr. 39
 64625 Bensheim
 Germany

Case Number

filled by Dentsply Sirona

Customer Information

Customer Name	Name of Treating Doctor (if different from reporter)
Customer No.	Job title
Job Title	Street
Contact	Zip code/ City
Street	Phone
Zip Code/City	
Phone	

Patient Information

Patient ID	Date of Birth
Hospital ID No	Sex.

Product Information

Suspected Drug: Brand and batch if known:

Route	Dose	Frequency
Start Date	Stopp Date	Indication

Other Medication

Reported Events(s): Please describe the reaction and any treatment given:

Start Date	Stop Date	Drug Withdrawn:	Yes	No
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Further Information

Recovered	Recovered with sequelae	Recovering	Event ongoing	Fatal	Unknown
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Date reported	Time reported
Report received by	Report submitted by

Shipping Label

Sender <hr/> <hr/> <hr/> <hr/>	
<p>Dentsply Sirona Deutschland GmbH Complaint Department Fabrikstr. 39 64625 Bensheim Germany</p>	