HOXWORTH BLOOD CENTER
CUSTOMER COMPLAINT FORM

Date Reported to Hoxworth: _____ Hospital/Customer Name: _____

Date/Time of Incident: _____

Name of Person Reporting Incident: _____

Name of Hoxworth Employee (involved in/receiving complaint): _____

Type of Product: _____

Unit Number(s): _____

Describe the Problem: (Be as detailed as possible) : _____

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Please fax ASAP to 513-558-1279

Hoxworth Blood Center
3130 Highland Avenue
Cincinnati, Ohio 45267-0055

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