



Reporter details	Full name (If several persons are making the complaint jointly, give the name of the person to whom the decision is to be sent)	
	Mailing address (The decision in respect of the complaint and any questions regarding processing of the matter will be sent to this address)	
	Postal code	City/town and country
	Telephone number	
	E-mail address	
	Relationship to Patient	
Patient details	Full name	
	Social security number	
	Mailing address	
	Postal code	City/town and country
This complaint concerns (Specify health care or medical care unit or individual service provider or professional)		
Short description of reason for complaint (Describe treatment, operation or such during which the suspected medical malpractice occurred)		
Time or time span of the event		

Details of the event and reason for discontent. If necessary, please continue to a separate annex.

Have you consulted a patient ombudsman of the health care or medical care unit?	Yes	No
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Have you submitted an objection to the health care or medical care unit concerning the case? (If so, append the objection and reply to it to the complaint)	Yes	No
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If other authorities have been involved with the case specify which.	<input type="checkbox"/> the Consumer Disputes Board of Finland	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> the Patient Insurance Centre of Finland	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> the Regional State Administrative Agency of _____ (specify region)	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> social care authority _____ (specify authority)	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> police authority _____ (specify authority)	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> the parliamentary ombudsman of Finland	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> Chancellor of Justice	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> Data Protection Ombudsman	<input type="radio"/> Case pending	<input type="radio"/> Closed
	<input type="checkbox"/> Other; specify _____		

Signature

Your signature
Clarification of signature
Place and date

Appendices	
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Sign and mail this form and appendices to:	Valvira, the National Supervisory Authority for Welfare and Health P.O.Box 43 FI-00521 Helsinki, Finland
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