CLINICAL+ SKIN®	**Adverse Events Complaint Form**	**Version no.: 1.0** **Page: 1/1**

Send completed form to Clinical Skin via adverseevents@clinicalskin.com

PATIENT ASSISTANCE PROGRAM USE ONLY – CONTACT INFORMATION:			
Full Name:	Phone:	Email Address:	
REPORT TYPE	☐ Adverse Event ☐ Product Quality Complaint ☐ Both	**FIRST AWARENESS DATE** (first contact date, mm/dd/yyyy):	

REPORTER INFORMATION

First Name: _____ Last Name: _____

Occupation: ☐ Parent/Patient ☐ HCP ☐ Pharmacist ☐ Nurse ☐ Other (Specify) _____

Phone: _____ Email Address: _____

Contact Mode: ☐ In person ☐ Email ☐ Phone call ☐ Mail ☐ Other(Specify) _____

PRODUCT

Product Name: Lot #:

Dosage: Therapeutic Indication:

When treatment started: _____ When treatment stopped: _____

Or specify if the treatment is ongoing: ☐

If unknown, indicate treatment duration:

For Product Quality Complaint, is the product available for return? ☐ Yes ☐ No

COMPLAINT (Product Quality or Adverse Event)

Detailed description: _____

_____

_____

☐ Ongoing ☐ Recovering

When event started: _____ When event stopped: _____ ☐ Recovered ☐ Unknown

Did the patient see a Health Care Provider (HCP): ☐ Yes ☐ No ☐ Unknown

If yes, same as reported? ☐ Yes ☐ No

Was the patient treated? ☐ Yes ☐ No ☐ Unknown Describe treatment:

PATIENT

Initials (F-LLL): _____ Date of birth (mm/dd/yyyy): _____ Gender: ☐ Male ☐Female

Age: _____ Months/Year(s) Weight (lbs): _____ Height: _____ Feet _____ Inches

Do we have permission to contact his/her **Parent or HCP**? ☐ Yes ☐ No

If yes, please provide contact details below:

Name: _____ ☐ HCP ☐ Parent

Phone: _____ Email: _____

Address:

CONTACT INFORMATION OF THE PERSON FILLING THIS FORM:

Name: Contact details (preferred mode):

Signature: **Date:**