Pierre Fabre USA	# Complaint Form FORM_USA_5518	**Version no.: 3.0** **Page: 1/1**

Send completed form to Pierre Fabre via us.safety@pierre-fabre.com or fax to 973-898-6573

US Case # _____ Corporate Case # _____

REPORT TYPE ☐ Adverse Event ☐ Product Quality Complaint ☐ Both

REPORTER

Name: (First) _____ (Last) _____

Occupation: ☐ Consumer ☐ HCP ☐ Pharmacist ☐ Nurse ☐ Aesthetician ☐ Other (Specify) _____

Phone:______ Email Address: _____

Address: _____

PRODUCT

Product Name: ______ Lot #:______

Dosage: _____
Therapeutic Indication: _____
When started treatment: _____
When stopped treatment: _____ Or specify if the treatment is ongoing: ☐
If unknown, indicate treatment duration:______

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

COMPLAINT (Product Quality or Adverse Event)

Description: _____

_____

When event started _____ When event stopped _____ ☐Ongoing ☐Recovering ☐Recovered ☐Unknown

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

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

PATIENT

Initials (F-LLL): ______ Gender: ☐ Male ☐ Female
Date of Birth (mm/dd/yyyy): _____/_____/_____Age: _____ Year (s)/Months
Weight: _____lbs Height: _____ feet _____ inches

If we have permission to contact his/her HCP, please provide HCP’s contact details.

Heath Care Provider Name: _____

Phone: _____ Email: _____

Address:______

Name: ______ **Signature:**_____

Contact Details: _____ **Date:** _____