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INCIDENT REPORT

FOR MEMBERS OF THE CANADIAN ASSOCIATION OF NATUROPATHIC DOCTORS

In the event of a patient's malpractice complaint please complete and return this form to Partners Indemnity Insurance Brokers as soon as possible. On receipt of the completed form you will be contacted.

ND'S CONTACT INFORMATION:

NAME: _____

MAILING ADDRESS: _____

PHONE NO: _____ FAX NO: _____ E-MAIL: _____

PATIENT'S CONTACT INFORMATION:

NAME: _____ DATE OF THE COMPLAINT: _____

MAILING ADDRESS: _____

PHONE NO: _____

PROVIDE COMPLETE DETAILS OF THE PATIENT'S COMPLAINT(S). ATTACH ADDITIONAL PAGES IF NECESSARY: _____

ND'S SIGNATURE: _____

DATE: _____