HOXWORTH BLOOD CENTER
CUSTOMER FEEDBACK FORM

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

Date/Time of Occurrence: _____

Name of Person Providing Feedback: _____

Type of Product: _____

Unit Number(s): _____

Description of Events: (Be as detailed as possible; include name(s) of Hoxworth Department(s) and staff involved):

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Please fax ASAP to 513-558-1279

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