

## Istituto Superiore di Sanità

Department of Infectious Diseases Unit of Foodborne and Neglected Parasitic Diseases



EUROPEAN UNION REFERENCE LABORATORY FOR PARASITES

## **CLAIM FORM**

Name			
Laboratory			
Address			
Tel.	Fax	e-mail	

Description:	
Date:	Signature:

## Do not fill in this section

Request received on \_\_\_\_\_

By the Director						
the claim is valid?	YES 🖬 NO 🖬					
action to be implemented following the claim (correction of the specific inadequacy, corrective action/s, information to be forwarded to the participant, etc.):						
to be implemented before:						
-						
			Signature:			
The planned action has be	en implemented?	YES 🗆 NO 🗖				
The participant was inform	ned on the action implemer	nted on:	YES			
The participant declared to	be satisfied with the action	on implemented	YES			
Date:			Signature:			