

Department of Infectious Diseases Unit of Foodborne and Neglected Parasitic Diseases



EUROPEAN UNION REFERENCE LABORATORY FOR PARASITES

## CLAIM/APPEAL BY PROFICIENCY TESTING PARTICIPANT

Name			
Laboratory			
Address			
Tel.	Fax	e-mail	

Description:	
Date:	Signature:

## Do not fill in this section

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

By the Director				
the claim/appeal is valid?				
action to be implemented following the claim/appeal (correction of the specific inadequacy, corrective action/s, information to be forwarded to the participant, etc.):				
to be implemented before:				
Date:		ignature:		
The planned action has been impleme	nted? YES 🗆 NO 🗖			
The participant was informed on the a	ction implemented on:			
The participant declared to be satisfie	d with the action implemented			
Date:	Sigr	Signature:		