



## 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?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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: _____	Signature: _____
The planned action has been implemented?	YES <input type="checkbox"/> NO <input type="checkbox"/>
The participant was informed on the action implemented on: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
The participant declared to be satisfied with the action implemented	YES <input type="checkbox"/> NO <input type="checkbox"/>
Date: _____	Signature: _____