

SERVICE INCIDENCE FORM

Ziacom Medical SL
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Nº _____

CUSTOMER INFORMATION		Mandatory data*	
Customer name*		Customer Ziacom® No.*	
Contact person*		Request date*	/ /
Full address*		Post Code*	
Clinic e-mail*		Clinic telephone No.*	

DESCRIPTION OF THE SERVICE INCIDENCE

Please, describe the incidence in detail.

FILL IN BY ZIACOM®

Complaint analysis
 Why it happened? Done by _____ Date / /

Corrective actions
 What will be done to eliminate the effects
 of the incidence and solve the problem? Done by _____ Date / /

Data Protection. **RESPONSIBLE:** Ziacom Medical SL. **PURPOSE:** To carry out the activity of the contract legitimately signed by the parties or commercial/contractual relationship. **LEGITIMACY:** Execution of a contract or commercial/contractual relationship. **ASSIGNMENTS:** To Group companies and third parties, in order to facilitate the processing of the conditions and relations foreseen in the contract/ commercial/contractual relationship, and assignments in compliance with the regulations in force. **CONSERVATION:** During the term of the contract or commercial/contractual relationship, and during the legally established terms. **RIGHTS:** You may exercise your rights of access, rectification, portability and limitation at juridico@ziacom.com. More information on the privacy policy at www.ziacom.com/en/privacy-policy.

