REPUBLIC OF CYPRUS

MINISTRY OF HEALTH

APPLICATION OF PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE LAW (L149(I)/2013)

COMPLAINT APPLICATION FORM (ARTICLE 9(1))

SECTION I: PERSONAL DETAILS OF THE APPLICANT

Name:.. Surname...

Date of Birth:....../......./.............. Identification Card No:...

Address:..., No.: ...., City/Town:.....................................

Postal Code:................., District:.........................., Country: ....

Telephone No.: ...., E-mail :..

Facsimile No:.............................

SECTION II: DESCRIPTION OF THE COMPLAINT

(a short description of the facts related to the specific complaint)

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Signature: .... Date: ....

Note:

*The present application form should be returned **duly completed** to the National Contact Point of the Ministry of Health through e-mail: ncpcrossborderhealthcare@moh.gov.cy or through facsimile on +357 22 605 499 / 492 **and** through regular mail or by Hand to the Ministry of Health, 1 Prodromou and 17 Chilonos Street, 1448 Nicosia, Cyprus.*