The Medical Professionals Association
Of Trinidad and Tobago
86 Main Road, Chaguanas
Tel: 671-6557, Fax: 671-9483

MPATT COMPLAINT FORM

NAME: _____ DATE: _____

EMPLOYED AS _____IN THE _____
DEPARTMENT & HOSPITAL NAME/HEALTH CARE FACILITY

BY THE: NWRHA [ ] SWRHA [ ] NCRHA [ ] TRHA [ ] ERHA [ ] MOH [ ]

RELEVANT DETAILS:

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TO WHOM IT MAY CONCERN

This is to confirm that I am a bona-fide financial member of the Medical Professional Association of Trinidad and Tobago (MPATT).

I hereby formally and officially authorize MPATT to act solely on my behalf with respect to: _____

_____

_____

_____which occurred on the _____ of _____, 20____.

Yours sincerely,

---------- EMAIL/PHONE CONTACT:_____