

**Rua Victório Viezzer, 84, Vista Alegre, Curitiba, PR, CEP 80.810-340**

**(41) 3240-4000 |** [**www.crmpr.org.br**](http://www.crmpr.org.br) **|** **protocolo@crmpr.org.br**

#### FORMULÁRIO DE DENÚNCIA

**OBRIGATÓRIO PREENCHIMENTO DO ENDEREÇO COMPLETO**

**NÃO SERÃO ACEITAS DENÚNCIAS ANÔNIMAS**

**LEMBRE-SE DE ASSINAR NO FIM DO DOCUMENTO**

**NOME DO DENUNCIANTE:**

**GRAU DE PARENTESCO COM O PACIENTE:**

### RG/UF:

### CPF:

TELEFONE(S) PARA CONTATO: ( )

ENDEREÇO COMPLETO (rua, número, bairro, cidade, estado e CEP):

**NOME DO PACIENTE:**

### RG/UF:

### CPF:

TELEFONE(S) PARA CONTATO: ( )

ENDEREÇO COMPLETO (rua, número, bairro, cidade, estado e CEP):

**Nome do(s) denunciado(s) (médico(s)):**

* **CRM-PR**
* **CRM-PR**

**Local de Atendimento: MENCIONAR A CIDADE DO HOSPITAL/CLÍNICA/CONSULTÓRIO:**

* **DATA:**

**ANEXOS: (Relacione aqui os documentos que irá entregar junto com a denúncia. Caso a denúncia seja enviada por e-mail, este formulário, devidamente assinado, assim como os anexos, devem ser digitalizados e enviados para protocolo@crmpr.org.br. Em caso de entrega pessoalmente na sede ou Representação Regional do CRM-PR, é necessário incluir as cópias impressas.)**

**RELATO COMPLETO DOS FATOS:**

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NESTES TERMOS, DECLARO QUE AS INFORMAÇÕES CONTIDAS NESTE FORMULÁRIO SÃO VERDADEIRAS E SOLICITO ANÁLISE DESTE CONSELHO REGIONAL DE MEDICINA DO PARANÁ.

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**Assinatura do denunciante.**

**Assinale qual o motivo do contato com o CRM-PR:**

**( ) Denúncia**

**( ) Solicitação de Parecer**

**( ) Solicitação de informação**

**(Após assinado, este formulário poderá ser digitalizado e enviado para o e-mail** **protocolo@crmpr.org.br** **ou entregue pessoalmente na sede ou Representação Regional do CRM-PR)**