# BIRIPI
## ABORIGINAL CORPORATION MEDICAL CENTRE

# COMPLAINT AND FEEDBACK

Date Received ______________

Reference № __________ - __________

## 1. ISSUE RAISED

☐ COMPLAINT (PAP-HRCS-00013) ☐ SUGGESTION ☐ COMPLIMENT

## 2. TYPE OF ISSUE

☐ SERVICE ☐ ADMINISTRATION ☐ SUPPORT STAFF ☐ OTHERS

## 3. DESCRIPTION

[Include LOCATION and RISK ASSESSMENT RATING, if applicable]

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## 4. BACKGROUND

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## 5. PERSON COMPLETING THIS FORM

☐ CLIENT ☐ CARER ☐ STAFF ☐ MEMBER OF THE PUBLIC ☐ OTHER ☐ ANONYMOUS

Raised by ______________________________ ______________
FULL NAME OF PERSON **COMPLETING** THIS FORM DATE

Received by ______________________________ ______________
FULL NAME OF PERSON **RECEIVING** THE ISSUE DATE

Verified by ______________________________ ______________
FULL NAME OF PERSON **VERIFYING** THE ISSUE DATE

DISCLAIMER: INFORMATION COLLECTED WILL BE FOR INTERNAL PURPOSES ONLY IN IMPROVING OUR SERVICES. INFORMATION WILL NEITHER BE USED AGAINST YOU NOR WILL BE SHARED TO A THIRD PARTY. PERSONAL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL ACCORDING TO BIRIPI ACMC PRIVACY POLICY.

## 6. HOW WOULD YOU PREFER TO BE CONTACTED REGARDING THE ISSUE RAISED?

☐ PHONE CALL ☐ SMS ☐ EMAIL ☐ POST ☐ NOT REQUIRED

Name ______________________________

Contact Details ______________________________

## 7. RESOLUTION

[Intended Corrective Action/s, Expected /Suggested Outcome]

I – Containment Action ACTION BY: ______________ DATE: ______________

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# BIRIPI
## ABORIGINAL CORPORATION MEDICAL CENTRE

II- Short/Long Term Action ACTION BY: ____________ DATE: ____________

OFFICE USE ONLY

**8. OUTCOME** ☐ SATISFIED ☐ UNSATISFIED ☐ FURTHER ACTION/S REQUIRED

NOTES: ____________

RESPONDED BY ____________

POSITION ____________

CLOSED-OUT DATE ____________