BIRIPI
ABORIGINAL CORPORATION MEDICAL CENTRE

COMPLAINT FORM

Part A: FOR COMPLETION BY PERSON MAKING COMPLAINT or ANOTHER PERSON ON THEIR BEHALF

Date: _____

PERSON MAKING A COMPLAINT:

Name: _____

Address: _____

Telephone: _____ Mobile: _____

PERSON COMPLETING THIS FORM (if different from person making the complaint):

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Relationship to person making complaint: _____

DETAILS OF COMPLAINT

If applicable, please include the following:

Date(s) of incident(s): _____

Location of incident(s): _____

Name(s) of employee(s) involved: _____

Name of anyone else present at the time: _____

Please summarise what you are concerned about (attach additional pages if necessary):

Signature of Person Making Complaint: _____