SUVA CITY COUNCIL
Health Services Department

COMPLAINTS CHECKLIST: **REF. #.....**
(DETAILS REQUIRED ON ALL COMPLAINTS RECEIVED)

A: FROM COMPLAINANT:

1. Date & Time Complaint received: ……
2. Name of Complainant: ……
   [Full Name of Complainant]
3. Complainants' Address (Res. or Office) ……
   ……
4. Telephone Contact [Home]…… [Workplace]……
5. Mode of complaint: ☐ Telephone ☐ Counter ☐ Letter ☐ Others ……
   [Please tick one of the above] *[Specify]*
6. Details of complaint……
   ……
   ……
   ……

Signature of complainant: ……
[If complaint received at Counter]

B: OFFICE USE:

1. Complaint received by: …… ……
   [Name] *[Signature]*
2. Date & time registered in complaint register: ……
3. Complaint referred to: …… Sign: ……
4. Date & time of referral: …… ……
   [Date] *[Time]*
5. Expected Outcome Date: ……
6. Remarks from Officer: ……
   ……
   ……
   ……
   ……
   ……

NB:

1 Please forward this form to the Director Health Services' Secretary / Customer Service Representative after receiving the complaints.
2 Action Officers to return the forms to the Director Health Services' Secretary/CSR within 2 days.