ACTIVE TIME PHYSIOTHERAPY

PAIN FREE LIFE

Complaint Form

Personal Information

- **Name**: _____**Or Anonymous**_____
- **Contact Number**: _____
- **Email Address**: _____
- **Preferred Method of Contact**: Phone / Email

Feedback/Complaint Details

- **Date of Service**: _____
- **Practitioner's Name (if known/applicable)**: _____
- **Location of Service** (if applicable): _____
- **Type of Feedback**: Compliment / Suggestion / Complaint

Description of Feedback/Complaint

Please provide a detailed description of your feedback or complaint. Include any relevant dates, times, and the names of any individuals involved.

_____

_____

_____

Desired Outcome

Please let us know what outcome or resolution you are seeking with your feedback or complaint.

_____

_____

Supporting Documentation (if applicable)

Please attach any supporting documents or evidence related to your feedback or complaint. (Note: This can include photos, emails, and other relevant documents.)

Consent (please read and tick)

- I consent to my feedback/complaint being used for the purpose of improving services and resolving any issues. I understand my personal information will be handled in accordance with the practice's privacy policy. I understand the services provided to me will not be affected by this complaint.

Submission (Please read and tick)

- Please submit this form to the practice Director or through the provided submission methods (email, in-person, Anonymous suggestion box, or directly to the NDIS commissioner for major complaints)

- **Date of Submission**: _____
- **Signature**: _____

Office Use Only

- **Received By**: _____
- **Date Received**: _____
- **Initial Assessment Completed**: _____
- **Follow-Up Action**: _____
- **Resolved YES/ NO** _____
- **Parties informed of resolution YES/NO** _____