Government of **Western Australia**
Department of **Health**
Health Corporate Network

Delivering a Healthy WA

Customer Complaint Form

Language other than English	Yes / No
Interpreter required	Yes / No
Interpreter used	Yes / No

Complainant details

Name _____

Address 1 _____

Address 2 _____ State_____ Postcode _____

Ph: (W) _____ Ph: (H) _____ Mobile:_____

Email: _____

Service area		
Human Resources	☐ Employment Services	☐ Payroll Services
	☐ NurseWest	
Supply	☐ Purchasing	☐ Accounts payable (Suppliers)
	☐ Tenders	
Finance	☐ Accounts receivable (Patients)	☐ Accounts payable (VMP's)
General	☐ Other	

Date of complaint: Date of incident:

Summary of Complaint - (What happened, who was involved)

Outcome required (What do you want to happen?)

Health Corporate Network use only		
Who received the complaint?	Date:	Written / Verbal
Action taken:		
Outcome for customer:		
Resolving Officer:		
Complainant notified of closure: Yes / No	Date:	
What system improvement was made as a result of this complaint?		
Categories of complaint		(Explanation)
Access	☐	
Communication	☐	
Decision making	☐	
Costs	☐	
Professional Conduct	☐	