## CUSTOMER COMPLAINT RECORD

### Part 1: Company Details (to be completed by the person issuing the complaint)

- **Reporters Name**
- **Company Name**
- **Contact Number and Email Address**

### Part 2: Complaint Details (to be completed by the person issuing the complaint)

- **Date:**
- **Complaint Related To:** (please tick appropriate field)
  - Product
  - Service
  - Delivery
  - Administrative:
  - Other (Please specify):

### Part 3: ACTION (To be completed by the Responsible Person at Medicare Hospital Equipment)

- **Complaint Received by:** (Name)
- **Date Received:**
- **Manner of Complaint Received** (in writing, in person, phone call)
- **Routed to:** (Name)
- **Date Routed:**
- **Manner of Complaint Routed** (in writing, in person, phone call)
- **Action Taken** (up to and including the final response)

- **Complaint Closed by:** (Name)
- **Date Closed**
- **Sign-off By:** (Name)
- **Date Signed Off**