MUSCULAR DYSTROPHY
SOUTH AUSTRALIA

Feedback/Complaints Form

Feedback/Complaints Form
Person Making the Feedback/Complaint

Name:..

I am making a suggestion ☐

I am giving positive feedback ☐

I am making a complaint ☐

(Please tick one of the above boxes)

Address:...

....Postcode:..........................

Telephone:...(Home)..(Work)

Mobile: ....Email...

Preferred method of Contact: ....

Relationship to Muscular Dystrophy SA Client

☐ Self ☐ Advocate
☐ Parent ☐ Member of the Public
☐ Relative (specify ....)☐ Organisation (specify...............................)
☐ Friend ☐ Other (specify...)

Name of Client:...

Feedback/Complaint

What is your Feedback or Complaint? Provide as much detail as you can, including people involved, the service and location. You can attach additional information if you like:

....

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....Signed:...

....Date:......../......../........ (Complainant or their representative)