Health and Community Services
COMPLAINTS COMMISSION

Phone: (08) 8999 1969
Free call: 1800 004 474

Complaint Form

1. Details of person making complaint

Title _____ **Surname** _____ **First name** _____

Address _____

Suburb/Town _____ **Post Code** _____

Telephone (Business Hours) _____ **Telephone** (After Hours) _____

E-mail address _____

Do you require an interpreter or assistance with a special need? Yes ❑ No ❑

If Yes please provide details _____

Are you representing someone else in this matter? Yes ❑ No ❑

If Yes, please provide their details below, if No please go to section 2

Title _____ **Surname** _____ **First name** _____

Address _____

Suburb _____ **Post Code** _____

Telephone (Business Hours) _____ **Telephone** (After Hours) _____

E-mail address _____

Your relationship to this person _____

The consumer should sign the following authority:

I _____ *(consumer) consent to* _____ *(complainant) lodging my complaint with the HCSCC.*

Signature of Consumer/Guardian/ Next of Kin _____ *Date* ___/___/____

2. Provider of the Service – Individual or organisation.

Title _____ **Surname** _____ **Given Name** _____

Organisation _____

Address _____

Suburb _____ **Post Code** _____

Telephone (Business Hours) _____ **Telephone** (After Hours) _____

E-mail address _____

Have you contacted the provider yourself to try and resolve the complaint? Yes ❑ No ❑

Completed forms may be submitted via any of the below methods:

Mail
PO Box 4409
DARWIN NT 0801

Hand Deliver
5th Floor, NT House,
22 Mitchell Street,
DARWIN NT 0800

E-mail: hcscc@nt.gov.au

Fax: 08 8999 6067

3. Details of Complaint

Please summarise the issues of your complaint: (Who, what, when, where and how - Attach extra sheets if needed)

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

What do you hope to achieve by making this complaint?

1. _____
2. _____
3. _____

4. Authorities

1. Release of information: To assess a complaint adequately, it may be necessary for the HCSCC to obtain information such as medical records. To do this we require your permission to request information and the provider requires your consent to release it.

I _____ authorise the Commissioner for Health and Community Services Complaints or his/her delegate to access all or any information and documentation relating to my complaint, including medical records and any other information within the knowledge or possession of the provider/s named in the complaint form and I HEREBY EXPRESSLY AUTHORISE AND DIRECT such provider/s to release to the Commissioner or his/her delegate such information as may be requested by him/her in relation to my complaint.

Signature of Consumer/Guardian/ Next of Kin _____ Date ___/___/_____

2. Referral of complaint: The HCSCC usually sends a copy of the complaint to the provider for a response. We seek your permission to do this and to also refer this complaint, where appropriate, to another body.

I _____ authorise the Commissioner for Health and Community Services Complaints to forward a copy of my complaint to the provider or another person/body if required.

Signature of Consumer/Guardian/ Next of Kin _____ Date ___/___/_____

3. Signature of person making complaint _____ Date __ /__ /__