NDIS Complaint Submission

Our service is committed to providing high quality care and services and meeting your needs. We value your feedback – including complaints.

Please let us know what we do well and where we can improve our services.

Indicate your response below with an X.

This is a:	complaint		feedback	

Section 1: Your details

Do you want to remain anonymous? (Indicate your response with an X)

Yes		No	

Personal details

First Name:	
Last Name:	
Postal address:	
Telephone number:	
Mobile number:	
Email address:	

Do you require an interpreter?

Yes		No		If **yes**, which language?	

Are you providing feedback on another person's behalf? (Indicate your response with an X)

No *(go to Section 4)*		Yes	

Section 2: Feedback made on another person's behalf

Please provide the following details about the person on whose behalf you are acting:

First Name:	
Last Name:	
Postal address:	
Telephone number:	
Mobile number:	
Email address:	

Please provide details of your relationship to the person on whose behalf you are acting:

Are you a legal representative for the person who received the service?
(e.g. parent of a child under 18 years or guardian – indicate your response with an X)

Yes		No	

If **yes**, please provide details:

Does the person know you are making a complaint on their behalf? (Indicate your response with an X)

Yes		No	

If **no**, please provide the reason why:

Are we able to speak with the person who received the service? (Indicate your response with an X)

Yes		No	

If **no**, please provide the reason why:

Section 3: Other person's consent for feedback made on their behalf

If you are providing this feedback on another person's behalf, we require the consent of the other person to obtain and pass on personal information relevant to this feedback. Please provide evidence of this consent when submitting this form, e.g., signed consent (as provided below) from the person on whose behalf you are acting.

I, (insert name of person giving consent) give permission to (insert name of person receiving consent) to provide or collect relevant information on my behalf to assist with this complaint/compliment or feedback, as necessary.

Signature:		Date:	

Section 4: Please provide details of the service that the feedback concerns

Name of the service provider:	
Address of office location of service:	
Contact person's name and position in the service:	

Section 5: Please state your concerns

Please provide details of your main concerns, including what events led to making the complaint, compliment or feedback, approximate dates and who was involved.

Section 6: What action have you already taken in relation to this feedback?

Have you discussed your concerns with the service provider or another agency or person for assistance with these concerns? (Indicate your response with an X)

Yes		No	

If **yes**, with whom and what was the outcome?

Section 7: What outcomes would you like as a result of providing your feedback?

Section 8: Privacy

Bodyfit Allied Health is committed to protecting your privacy. We collect and handle personal information that you provide on this feedback form for the purpose of investigating and responding.

Bodyfit Allied Health will only use your information in accordance with relevant privacy and other laws. In order for us to provide services to you effectively and efficiently, we may need to share your personal information with others, such as Bodyfit Allied Health's Allied Health Manager that deals with the matters identified in your feedback.

If you choose to remain anonymous, Bodyfit Allied Health may be unable to deliver the full range of services you require.

If you wish to contact our Allied Health Manager who is responsible for managing the personal information that you provide on this form, please call 08 8981 2886 and request to speak to Jamie Chan.

Section 9: Declaration

By signing you are declaring that all information is true and correct to the best of your knowledge.

Signature:		Date:	

Thank you for taking the time to provide feedback about our service.

Please submit this form in person at the place of practice at which it relates OR via email to admin@bodyfitnt.com.au

Section 10: Follow Up (Office Use Only)

Is any follow up action required? If yes, what?

Name of team member to perform follow up:

Date of follow up actions:
Signature: