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**ACCESSIBILITY**

**CLIENT/CONSUMER FEEDBACK FORM**

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| Name of the Client/Consumer  |
| Address | City |
| Province | Postal Code | Phone | Fax (optional) |
| E-mail |
| Complaint: |
| **FOR INTERNAL USE ONLY** |
| Complaint taken by: (Employee Name) | Date Complaint Received: |
| Program/Service: (List the programs or services that the complaint was about.) |
| Complaint Causes: (Describe the causes of the complaint and how the client/consumer was affected.) |
| Corrective Action: (Describe the action that was taken to satisfy the client/consumer.) |
| Has the resolution been communicated to the client/consumer? 🗆 Yes 🗆 No |
| If no, provide reason: |
| If no, indicate date client/consumer will be informed of the resolution. | Date:  |
| How will the problem be avoided in the future? |
| Date Complaint Closed:  | Date Complaint Reviewed by Manager: | Date Complaint Entered Into Spreadsheet: |

**Form to be returned to the Director of Branch Services**

**jkirychuk@cmha-tb.on.ca**