

**VICTORIAN ABORIGINAL HEALTH SERVICE – COMPLAINT FORM**

**Use this form to make a complaint.** Please provide as much information as you can, so we can help you.

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| 1. Your details | | | | | | | | | | |
| Title: | First name: | | | | | | Last name: | | | |
| Middle name: | | | | | Gender: Female Male | | | | | Date of birth: |
| Postal address: | | | | | | | | | | |
| Suburb/town: | | | State: | | | | | Postcode: | | |
| Daytime telephone: | | | Mobile: | | | | | Email: | | |
| My preferred method of contact is: | | Telephone | | Email | | Letter | | | Other  Details: | |
| Do you identify as Aboriginal and/or Torres Strait Islander? No Aboriginal Torres Strait Islander Both | | | | | | | | | | |
| Your preferred language: | | | | | | | Your country of birth: | | | |
| Do you have any special needs? No Yes  Please specify: | | | | | | | | | | |
| Are you making this complaint on behalf of someone else? No Skip to 3. Yes  Go to 2. | | | | | | | | | | |

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| 2. Details of the person you are complaining on behalf of | | | | | | | |
| Title: | First name: | | | | Last name: | | |
| Middle name: | | | Gender: Female Male | | | | Date of birth: |
| Postal address: | | | | | | | |
| Suburb/town: | | State: | | | | Postcode: | |
| Daytime telephone: | | Mobile: | | | | Email: | |
| What is the person’s relationship to you? Next-of-kin Other | | | | Has the person asked you to make this complaint? No Yes | | | |
| Is the person a child? No Yes | | | |  | | | |
| Does the person identify as Aboriginal and/or Torres Strait Islander? No Aboriginal Torres Strait Islander Both | | | | | | | |

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| 3. Who is this complaint about? (Please include as much information as possible). | | | | |
| First name: | | Surname: | | |
| Type of health service provider (e.g. doctor, dietician, health worker): | | | | |
| VAHS Employee: Yes | | | No: | |
| If more than one person involved: | First Name: | | | Surname: |
| Type of health service provider (e.g doctor, dietician, health worker): | | | | |

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| 4. How have you tried to resolve this complaint? |
| Have you already complained to VAHS?  No  Yes  Please provide details of person/s you have already spoken to and date |
| Date the health service was provided: |

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| 5. Your complaint |
|  *Tell us:*  *What happened*  *Who was involved*  *When and where it happened*  *When you become aware of the problem*  *The main issues you are concerned with.*   *Attach another page if you need more space. Attach copies of any supporting information—letters, reports, photos, invoices.* |
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| What would you like to happen to resolve your complaint?  E.g acknowledgement / apology /disciplinary action / policy/process change Details:   |  | | --- | |  | |

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| 7. Send us your complaint form |
|  **Mail:** 186 Nicholson St Fitzroy Vic 3072  **Fax:** (03) 9403 3333  **Email:** complaints@vahs.org.au  *We will contact you within 7 days of receiving your complaint form. (Note: emails may appear in junk mail, depending on your settings.)*  |