



**LOCAL HEALTH AUTHORITY**  
**INTERNAL COMPLAINT FORM**

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

NAME: \_\_\_\_\_

CONTACT NO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**NATURE OF COMPLAINT:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INVESTIGATION:**

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\_\_\_\_\_

\_\_\_\_\_

**ACTION TAKEN:**

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Request Taken by:**

\_\_\_\_\_  
**Foreman Other Services**