Compliment form

ACT AMBULANCE SERVICE
ACT EMERGENCY SERVICES AGENCY

Please return completed form to;
ACT Ambulance Service
Chief Officer
GPO Box 158
Canberra ACT 2601

Patient details

Mr/Mrs/Ms (other): ____ First name: _____ Surname: _____

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: _____

Phone (business hours): _____ Phone (after hours): _____

E-mail address: _____

Preferred method of contact: _____

The patient's preferred language is _____

If you were not the patient, please list your details below

Mr/Mrs/Ms (other): ____ First name: _____ Surname: _____

Address: _____

Suburb: _____ Postcode: _____

Phone (business hours): _____ Phone (after hours): _____

E-mail address: _____

My relationship to the patient: _____

Preferred method of contact: _____

My preferred language is _____

My compliment relates to

Administration	☐	Response Time of Ambulance	☐
Communications	☐	General level of service	☐
Clinical Treatment	☐	Other	☐

What was the date that your compliment relates to? _____

Please provide the details of your compliment

- Please include information about what led up to the compliment, what happened and who was involved.
- If there is not enough space to describe your compliment, please attach extra paper.
- Please attach any relevant documents.

Authorisation

I authorise the Chief Officer and/or their delegate to obtain information and health records relevant to this compliment. I understand that;

- the Chief Officer and/or their delegate may release a copy of my compliment to appropriate members of the ACT Ambulance Service; and
- the Chief Officer and/or their delegate may release to the administrator and other people dealing with this compliment, a copy of my compliment, health records and/or other personal information;

Signature: _____ Date:_____