



Your Feedback or Complaint

Would you like to;	<input type="checkbox"/> Provide Feedback	<input type="checkbox"/> Make a Suggestion	<input type="checkbox"/> Make a Complaint
Would you like to;	<input type="checkbox"/> Remain anonymous	<input type="checkbox"/> Provide contact details below	
First Name:		Last Name:	
Telephone:		Email:	
Suburb:		State:	
Post Code:		Order Number (If known)	

I am a;			
<input type="checkbox"/> Customer	<input type="checkbox"/> Family member or friend	<input type="checkbox"/> Support Coordinator	<input type="checkbox"/> Allied Health Professional
<input type="checkbox"/> Disability provider	<input type="checkbox"/> Disability worker	<input type="checkbox"/> Advocate	<input type="checkbox"/> Carer
<input type="checkbox"/> Other (please specify)			
Are you making this feedback/complaint on behalf of an NDIS participant;		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Brief summary of your feedback/complaint:



What do you suggest we do to resolve your issue?

Would you like us to contact you regarding your feedback/complaint?

☐ Yes ☐ No

Would you like us to contact you by;

☐ Email ☐ Phone ☐ No contact required

How disappointed or how happy are you with the TabTimer product you purchased?

☐☐☐☐☐

How disappointed or how happy are you with the service you received from TabTimer?

☐☐☐☐☐

How disappointed or how happy are you with TabTimer overall?

☐☐☐☐☐

Signature

Signature of the Person Submitting this Form

Name

Name of the Person Submitting this Form (print)

Date of Signature

MM

DD

YY

Please email this form to info@tabtimer.com.au, or post it to:- TabTimer, PO Box 7395 ALEXANDRIA NSW 2015.
If you need help please let us know. If required, we will respond within 5 days.