GOMOA WEST DISTRICT ASSEMBLY

CLIENT COMPLAINT FORM

NAME OF COMPLAINANT/ INSTITUTION:				**Client (or proxy) Contact Details** **(Address/Tel. no./location/email/community).**		
AGE BRACKET	**BELOW 18** **18 – 40** **41 – 60** **ABOVE 60**	□ □ □ □	**Mode of complaint (walk-in/phone call/social media/official website etc.)**		**Gender:** **Disability:**	

BRIEF OF COMPLAINT

Written by: Complainant CSU Other Staff	□ □ □	Client sign/Thumbprint		CSU Officer sign:	

For Official Use Only

Instruction by Administrative Head (CD/RCD/MMDCD)				
DATE:		SIGN:		

Acknowledgment by Action officer(s)

Name & Signature of officer/Date:		**Position/Grade:**	
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