

COMPLAINT FORM

Type City/County Name Below

Company Information If Known

CITY/COUNTY NAME		
COMPLAINT REC'D BY		COMPANY NAME:
OFFICE NUMBER		SYSTEM MANAGER:
FAX NUMBER		OFFICE NUMBER
EMAIL ADDRESS:		FAX NUMBER

CUSTOMER INFORMATION:

CUSTOMER NAME		HOME PHONE	
ADDRESS		OFFICE PHONE	
CITY		FAX NUMBER	
TELEPHONE NUMBER			

TYPE OF COMPLAINT	<input type="checkbox"/> NO SERVICE	<input type="checkbox"/> POOR RECEPTION	<input type="checkbox"/> PHONE RESPONSE
CHECK ONE OR MORE	<input type="checkbox"/> BILLING	<input type="checkbox"/> PROGRAMMING	<input type="checkbox"/> RATES
	<input type="checkbox"/> MISSED APPT	<input type="checkbox"/> DAMAGE	<input type="checkbox"/> OTHER:

DATE OF COMPLAINT

DESIRED OUTCOME

DESCRIPTION OF COMPLAINT

FAX COMPLETED FORM TO GMA AT 678-678-6374 OR EMAIL TO <CABLECOMPLIANCE@GMANET.COM >

COMPLAINT RESOLUTION COMPANY HAS FIVE (5) BUSINESS DAYS TO RESPOND TO CUSTOMER

DATE RECEIVED BY GMA RESOLVED BY

DATE RESOLVED TITLE

COMMITMENT TO CUSTOMER

COMPANY: Fax Completed Form to Franchise Authority and to GMA within 7 Business Days of "Date Received."