RECORD OF FEEDBACK on ACCESSIBILITY STANDARD OF CUSTOMER SERVICE

Date feedback received: _____

Name of Individual providing feedback (optional): _____

Details: _____
_____
_____
_____
_____
_____
_____

Follow-up: (in ten business days or less depending on urgency) Date: _____

_____
_____
_____
_____
_____
_____

Action to be taken:

_____
_____
_____
_____
_____
_____

By whom: _____

REVIEW

Information provided if requested: ☐ Yes ☐ No

Within timelines: ☐ Yes ☐ No If no, why? _____
_____
_____

Forwarded to:
- ☐ Department Lead (VP, Director or Manager) – for follow up
- ☐ Accessibility Advisory Committee – for next meeting
- ☐ Included in tally of responses