

COMPLAINT FORM

Type City/County Name Below

Company Information If Known

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

COMPANY NAME:	
SYSTEM MANAGER:	
OFFICE NUMBER	
FAX NUMBER	

CUSTOMER INFORMATION:

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

T Y P E O F C O M P L A I N T	<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	
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DESIRED OUTCOME	
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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	
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DATE RESOLVED		TITLE	
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COMMITMENT TO CUSTOMER

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