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			

T YPE OF COMPLAINT		NO SERVICE		POOR RECEPTION	PHONE RESPONSE
CHECK ONE OR MORE		BILLING		PROGRAMMING	RATES
		MISSED APPT		DAMAGE	OTHER:

DATE OF COMPLAINT

DESIRED OUTCOME

DESCRIPTION OF COMPLAINT

FAX COMPLETED FORM TO GMA AT 678-686-6374 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."