ONEIDA NATION CHILD SUPPORT AGENCY
CUSTOMER COMPLAINT FORM

Customer Name:_____ Date of Complaint:__/__/____

Address:_____

City:_____ State:_____Zip:_____ Phone: (_____)_____

Incident Date:_____ Employee Name:_____

□ PROCEDURAL
□ Locate □ Support □ Genetic Testing /Paternity
□ General Case Mgt. □ Financials

-OR-

□ CUSTOMER SERVICE

Please Describe the issue:

_____
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Signature of person completing this form:_____

For Office Use Only: Date Received_____ By Whom:_____

Routed To: Supervisor ☐ _____ Area Manager: ☐ _____