UNIVERSITY OF LORALAI

Directorate of IT

ACCESS QUALITY RELEVANCE

IT SERVICES COMPLAINT FORM

To be filled in by the Complainant:

Name: _____

Designation: _____

Department: _____

Room No: _____ **Contact No:** _____

Nature of complaint: _____

_____

_____

Date: _____ **Signature:** _____

To be filled in by the Directorate of IT:

Complaint No: _____ **Date:** _____

Domain: **NETWORK/ SYSTEM**

Job Assigned to: _____

Result/ Report: _____

Date: _____ **Signature:** _____

Feedback from Complainant:

Comments: _____

_____

Date: _____ **Signature:** _____