



City of Torrance – Office of Cable & Community Relations
CABLE TELEVISION COMPLAINT – COMMENT FORM

Complaint received by: _____

Date: ____/____/____

If referred, by whom: _____

Dept.: _____

REQUIRED INFORMATION

Subscriber: _____

Email: _____

Address: _____

City: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Customer Service:
Level of Cooperation:
Billing:

Rates:
Programming:
Pay Per View:

Installation:
Installation:
Repair Service:

Cable Modem:
Rebuild:
Digital Programs:

Telephone:
Follow-up Required:
Other: _____

Nature of Complaint/Comment: _____

OFFICE USE ONLY:

Installation Date: ____/____/____ **Disconnect Date:** ____/____/____

Routed to: _____

Date: ____/____/____

Action: _____

Findings: _____

Resolution: _____

Date of Resolution: ____/____/____

Complaint Closed: ____/____/____

Telephone Complaint:

Written Complaint:

Walk-In Complaint:

Comment: _____

- R O U T E T O O F F I C E M A N A G E R -