College of Physicians & Surgeons of Alberta

Complaint Reporting Form

Our Complaints Process

Note: Please print, sign and mail this form to the College. We cannot accept electronic copies.

To begin an inquiry into your complaint please:

- **Complete this form**
- **Ensure all signatures are authorized and additional information is provided**
- **MAIL THE ORIGINAL completed form to the College's Professional Conduct Department**

The College will then:

1) Send a copy of your completed form to the physician(s) in question to obtain a response, as necessary.
2) Contact other individuals and institutions named in your completed form who may have information relevant to your complaint. They may receive a copy of your completed form.
3) Review any information received. Further communication with the parties involved may occur.
4) Provide you with a written response. The physician(s) will also receive a copy.

Note: Our complaints process can take several months depending on the complexity and severity of the complaint.

If you have any questions or need help completing this form, please contact a CPSA Patient Advocate at 780-423-4764 or toll free 1-800-661-4689.

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1) Person making the complaint

(Ms/Mrs/Mr/Dr) _____
○ ○ ○ ○ (first name) (last name)

○ I am the patient concerning this complaint

○ I am filing this complaint on behalf of the patient. I am the patient's _____
(state relationship)

(If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing your ability to do so. Examples include: executor of an estate, legal guardian, patient's written consent, etc.)

2) Patient information

Birth Date (dd/mmm/yyyy)_____ Alberta Health Care #_____

(Ms/Mrs/Mr/Dr) _____
○ ○ ○ ○ (first name) (last name)

3) Authorization for release of information: *(Click to open Release Form)*

Complete this form by providing the appropriate information and signatures. A completed form is necessary to perform a full investigation into your complaint. ***(NOTE: A witness is defined as any adult person who can confirm that he/she saw you sign the form.)***

4) Provide the full name of the physician(s) you wish to complain about along with his/her address and telephone number. *(Note: A copy of your complaint form will be sent to these individuals.)*

Physician Name	Address	Telephone Number

5) Provide the full name of any other individual(s) who may have information regarding this complaint. Please include the details of the information they may have about your complaint (e.g. other physician, therapist, witness(es) who were present), as well as their addresses and telephone numbers. Attach additional pages if necessary. (*Note: A copy of your complaint form may be sent to these individuals.)*

Name	Contact Information	Information details

Attach additional pages if necessary

6) If your complaint involves care you received in a hospital, provide the name(s) of the hospital(s), location(s) and date(s) you attended. *(These facilities may be asked to provide personal identifiable information, such as diagnostic, treatment and patient care information. A separate release may be required for the hospital.)*

Name of Hospital	City	Date(s) attended

Attach additional pages if necessary

7) **Provide a clear description of the complaint(s) you have about the physician(s) you identified in section #4.** Please include in your description what the physician did or failed to do to cause you to complain, including:

a. what happened;
b. where it happened; and
c. when it happened (in chronological order).

Attach additional pages if necessary

8) What do you hope will happen as a result of your complaint?

(NOTE: The College of Physicians & Surgeons of Alberta can not provide financial compensation nor can we direct or arrange patient care.)

Please attach any relevant information that will assist our inquiry into this complaint.

Privacy is important to us!

We collect, use and/or disclose your personal information with your consent unless otherwise authorized or required by legislation. As per our *CPSA Privacy Statement*, we collect and use your personal information to do our College work, which is to protect the public and to guide and regulate Alberta physicians.

Signature of person making complaint

Date signed (dd/mmm/yyyy)

When applicable: As the patient, I consent to the College of Physicians & Surgeons of Alberta disclosing information concerning my complaint (including personal identifiable information, such as diagnostic, treatment and patient care information) to the person making the complaint on my behalf.

Patient's signature

Date signed (dd/mmm/yyyy)

If the patient is deceased, please provide the date of death

Date of death (dd/mmm/yyyy)

Contact information for person filing this complaint:

Email _____ ☐ I agree to receive emails from the CPSA regarding this complaint

Telephone number with area code where we can contact you during the day (8:30 a.m. - 4:00 p.m.):

☐ Home (____)_____ ☐ Work (____)_____ ☐ Cell (____)_____

Address _____

City _____ Postal Code _____

MAIL THE ORIGINAL completed form to:

Professional Conduct Department
College of Physicians & Surgeons of Alberta
2700-10020 100 Street NW
Edmonton, AB T5J 0N3

PRINT FORM

Ensure you include the *Release of Information form*.
Please also print or save a copy of this form for your records.

Good Medical Practice - it's what we're all about

College of Physicians & Surgeons of Alberta

Authorization for Release of Information

I understand my signature on this release will allow the College of Physicians & Surgeons of Alberta to do the following in order to investigate certain matters under the *Health Professions Act*:

1. Obtain medical records or other information, as specified in the attached letter, relevant to my complaint issue(s) (medical records include person identifiable information, diagnostic, treatment and care documentation).
2. Provide a copy of my complaint to the physician(s) named and all other persons providing information.
3. Disclose, where applicable, information concerning my complaint including person identifiable information, diagnostic, treatment and care information to the person making the complaint on my behalf.
4. Use this original form for faxing/photocopying to collect information from physicians and facilities and the copy of this form shall be as valid as the original.

This will authorize the release of records, including medical information or otherwise, concerning:

Print Patient's Full Name _____ Date of Birth (dd/mmm/yyyy) _____

I understand why I have been asked to consent to the disclosure of this information and am aware of the risks or benefits of consenting, or refusing to consent, to disclose this information. I also understand that this consent is valid for a two-year period past the date signed and that I may revoke this consent in writing at any time.

Signature of Patient or Legal Representative* _____ Date Signed (dd/mmm/yyyy) _____

Print Witness's Full Name _____
(person who witnessed signature of patient or legal representative)

Signature of Witness _____ Date Signed by Witness (dd/mmm/yyyy) _____

**If you are the legal representative of the patient, please provide proof of guardianship, or if the patient is deceased, a copy of the will naming you as Executor/Executrix.*

Print Form

Print, sign and mail this form along with the Complaint Reporting Form to the College. Print or save a copy for your records.

File Number: _____
(College Use Only)