COMPLAINT FORM

1. Patient Information:

Ms/Mrs./Mr./Dr. (Circle one) Address ____________________________

Last Name ____________________ Town/City __________________________

Given Name ___________________ Postal Code _________________________

Birth Date _____________________ Telephone (home) ___________________

Manitoba Health No. ___________ Telephone (work) ___________________

P.H.I.N. No. ___________________ Cell phone ___________________
(9-digit # on back of MHSC card)

2. If not the patient, information from the person making the complaint:*

Ms./Mrs./Mr./Dr. (circle one) Address ____________________________

Last Name ____________________ Town/City __________________________

Given Name ___________________ Postal Code _________________________

Relationship to patient___________ Telephone (home) ___________________

_______________________________ Telephone (work) ___________________

*[Please note that only a legal representative of the patient or a deceased patient's estate (example: executor/executrix) may complain on a patient's behalf].

3. Provide the name of the physician complained about along with that physician's practice location. (If you are complaining about more than one physician, please submit a separate complaint form for each physician)

Physician (last name, first name or initials)	City/Town

4. Provide the name(s) of the hospital(s) attended either as an in-patient or for emergency/outpatient treatment relevant to the complaint, and the date(s) of those visit(s).

Name of Hospital	City/Town	Date(s)

5. Provide the name(s) of any other individual(s) who may have information pertaining to the complaint [e.g. family physician, other physician(s), or health care professional(s)].

Name	Location	Information

6. Provide a brief and clear description of the concern(s) you have about the physician named in the complaint.

If additional space is required, sign and number each page submitted.

7. In summary, please list in point form the questions/concerns you wish the physician to address.

If additional space is required, sign and number each page submitted.

8. What is your expectation from the review of this complaint? Please note that the College cannot award financial compensation, refer patients to physicians or arrange medical treatment/diagnostic tests.

______________________________ __________________________
Signature of person making complaint Date

____
Print Name

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I am aware that The College of Physicians and Surgeons of Manitoba ("the College') is reviewing concerns about the care provided to me and that the College is collecting my personal health information for the purpose of its review.

You are hereby authorized to furnish and release to the College, or its representative, any and all information which it requests for the purpose of its review relative to my health, including my mental, physical or other condition, my health history, any prescriptions or any other treatment provided to me and the results of any diagnostic procedures.

I am aware that this authorization may be used by the College to:

- Request and receive such personal health information as physician office records/charts, hospital records/charts, prescribing information, and billing records.
- Photocopy and disseminate this information as necessary for the review of my care in accordance with the College's complaints process.

This authorization shall continue until revoked by me, in writing. A photostatic copy of this authorization shall serve in its stead.

Signed by me in the City/Town of ____________________, in the Province of Manitoba, this ____ day of _______________ 201___.

______________________________	______________________________
WITNESS	SIGNATURE
	PRINT NAME

MB Health No. (6 digits): _______________

Date of Birth: __________________________

Please Return Requested Information to:

Complaints/Investigation Department
College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Ave.
Winnipeg, Manitoba
R3J 3T7