The College of
Physicians and Surgeons of Ontario

Complaint Form

To make a complaint, please complete this form and mail it the College at the address provided at the end of the form.

If you are the patient, the College will obtain your personal health information for the purpose of investigating your complaint.

If you are complaining on behalf of the patient, please have the patient sign the on-line consent form and forward it to the College.

Please note that we will notify the doctor of your complaint within 14 days after the College receives this information.

If you would like to talk to someone about the care and/or conduct of a physician or about the complaints process, please contact our **Public Advisory Department** at **416-967-2603 or 1-800-268-7096 x603** (toll free within Ontario).

What the College cannot do

- Address concerns or complaints about hospitals or other health care professionals (i.e. Nurses, Pharmacists, Chiropractors, Naturopaths) who are not registered with the College of Physicians and Surgeons of Ontario
- Provide diagnoses, referrals or treatment recommendations, or direct a patient's care
- Provide any financial compensation to patients, complainants or families
- Process complaints without notifying the physician(s) about the complaint

A. Person Registering Complaint

Last name _____ First name _____

Street _____ Apt # _____

City _____ Province _____ Postal code _____

Daytime telephone _____ Alt telephone _____

If you are not the patient, please describe your relationship to the patient and provide details about the patient in Section B.

Relationship to patient _____

B. Patient Information

☐ Same as Complainant or:

Last name _____ First name _____ ◯ Female ◯ Male

Street _____ Apt # _____

City _____ Province _____ Postal code _____

Daytime telephone _____ Alt telephone _____

Date of birth _____ Date of death (if applicable) _____

If the patient is not the complainant, please have the patient complete the online consent form as the College must obtain relevant personal health information in order to investigate. If the patient is deceased or otherwise unable to sign the consent form, it must be signed by:

- the legal guardian of the patient;
- the power of attorney for personal care; or
- the executor of the patient's will.

C. Physician you are complaining about

Please note that the College only has jurisdiction over individual physicians, and not other health care professionals or institutions.

Last name _____ First name _____

Street _____ Suite # _____

City _____ Province _____ Postal code _____

Daytime telephone _____ Specialty _____

Where did you see this physician? (click one)

◯ Hospital ◯ Office ◯ Walk-in clinic

◯ Other >>> Please specify: _____

When did you see this physician?

Dates of any treatments _____

D. Details of other physicians

Please identify any other physician(s) who provided you with medical care relevant to your concerns. If there are more than two physicians who may have information, please continue on a separate sheet.

Last name _____ First name _____

Street _____ Suite # _____

City _____ Province _____ Postal code _____

Daytime telephone _____ Specialty _____

Where did you see this physician?

◯ Hospital ◯ Office ◯ Walk-in clinic

◯ Other >>> Please specify: _____

When did you see this physician?

Dates of any treatments _____

Last name _____ First name _____

Street _____ Suite # _____

City _____ Province _____ Postal code _____

Daytime telephone _____ Specialty _____

Where did you see this physician?

◯ Hospital ◯ Office ◯ Walk-in clinic

◯ Other >>> Please specify: _____

When did you see this physician?

Dates of any treatments _____

E. Details of Hospital(s)/Facility(ies) Attended

Please provide the names of the hospital(s) or other care facilities and dates you attended during this period. If there are more than two facilities, please continue on a separate sheet. Written consent is required to obtain information from Hospital facility.

Facility name

Street

City Province Postal code

Date attended

Facility name

Street

City Province Postal code

Date attended

F. Details of Complaint

1. On a **separate sheet**, outline the details of your complaint.

2. Please **summarize** the details of your complaint by listing your **areas of concern** (care/behaviour, etc.):

   I.

   ii.

   iii.

If there are more than 3 areas of concern, please continue on a separate sheet

3. Why you are concerned about these areas?

4. A description of any efforts you have made to resolve this matter

G. Acknowledgement and Signature

NB: This section is only for a complainant who is also the patient

I have read and I understand the following:

I understand that the College of Physicians and Surgeons of Ontario (CPSO) will obtain my relevant personal health information as part of the investigation. The College will share some or all of the information and documents that it receives from me and other parties with the physician(s) complained about.

The information on this form is collected under the authority of the *Regulated Health Professions Act*, 1991. The information provided will be used to process my complaint.

I understand that if either I or the physician appeals the College's decision, medical information and other information collected during the investigation must be disclosed to the Health Professionals Review and Appeal Board, which is a public forum.

_____ _____

Date signed Signature of Complainant (patient)

Any questions regarding the collection or use of this information should be directed to the Investigations and Resolutions Department at the CPSO.

Please print out this form when completed, sign and mail to:

The Registrar
c/o Investigations and Resolutions Department
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON, M5G 2E2

Complaint Forms may **NOT** be returned to the College by email, as an original signature is required. All correspondence from us will be sent by regular mail to preserve confidentiality.

Find out more on our website at: http://www.cpso.on.ca/Policies-Publications/Complaints

Checklist

Have you completed the following?

- Full name(s) and address(es) of the physician(s) involved
- Complete description of the complaint
- Your name and a number where you can be reached during the day
- If the patient is not the complainant, a consent form has been completed, signed and dated by the parent, trustee or substitute decision maker:
- Signed and dated the acknowledgement section, if the complainant is also the patient.