

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.**

