THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7
Tel: (204) 774-4344 Fax: (204) 774-0750
Toll Free (MB only) 1-877-774-4344
www.cpsm.mb.ca

COMPLAINT FORM

1. Patient Information:

Mx/Ms/Mrs./Mr./Dr. (Circle one)

Last Name ____________________

Given Name ___________________

Birth Date _____________________

Manitoba Health No. ___________

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

Address __________________________

Town/City ________________________

Postal Code _______________________

Telephone (home) ________________

Telephone (work) _________________

Cell phone________________________

Email: ___________________________

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

Mx/Ms./Mrs./Mr./Dr. (circle one)

Last Name ____________________

Given Name ___________________

Relationship to patient__________

____

Address _________________________________

Town/City _______________________________

Postal Code ______________________________

Telephone (home) _______________________

Telephone (work) ________________________

Email: ____

*[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, another 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

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Print Name