



## College of Physicians and Surgeons of British Columbia

300–669 Howe Street  
Vancouver BC V6C 0B4  
[www.cpsbc.ca](http://www.cpsbc.ca)

Telephone: 604-733-7758  
Toll Free: 1-800-461-3008 (in BC)  
Fax: 604-733-3503

# Complaint Form

## INSTRUCTIONS

1. Complete this form (and, if applicable, the Authorization for Representation form)
2. Ensure all signatures are authorized and additional documentation is provided
3. Mail the completed form to the College's complaints department

The College reviews all complaints about physicians and/or surgeons licensed to practise medicine in British Columbia. All complaints are treated in the same manner and assessed through the same review process.

All complaints are reviewed in the order they are received. Please be aware that the review process is detailed and can be lengthy, depending on the circumstances. The length of time required for resolution will also vary. Once the College has received your complaint, you will be notified through mail. This letter will contain contact information of the College staff member responsible for your file. If at any time you would like an update on your complaint, please call this staff member with your file number ready.

### Before you submit the form, please consider that the College is not able to:

- provide diagnoses or treatment recommendations, or direct the specifics of patient care
- direct or influence the payment of financial compensation to complainants
- adjudicate complaints without offering the physician(s) the opportunity to respond
- assist with concerns or complaints about hospitals, or other health-care providers such as nurses, pharmacists, dentists, optometrists, psychologists, chiropractors, naturopaths, or any other health professional who is not a registered physician or surgeon—these should be directed to the appropriate organization or regulatory authority
- contact the police on behalf of the complainant where illegal activities are suspected without the complainant's specific consent

## CHECKLIST

### Have you completed the following?

- included the full name(s) and address(es) of the physician(s) involved
- described the complaint in as much detail as possible
- enclosed copies of documents that may support this complaint
- provided your name and a telephone number where you can be reached during the day
- signed and dated Authorization for Representation form, if applicable
- signed and dated the Confirmation box (page 2)
- checked that all five pages of this form are filled in and any separate sheets are attached

## When you have completed this Complaint Form, please send it by:

### MAIL Complaints Department

College of Physicians and Surgeons of BC  
300–669 Howe Street  
Vancouver BC V6C 0B4

**FAX** 604-733-3503

If you would like more information about the College's complaints process, please visit [www.cpsbc.ca](http://www.cpsbc.ca) or phone 604-733-7758 or 1-800-461-3008 (toll-free in BC).

**Thank you for taking the time to complete this form.**

Complaint Form *continued***PERSON REGISTERING THE COMPLAINT**

Title: \_\_\_\_\_ Full Name: \_\_\_\_\_  
 (Mr. Ms. Dr. etc.)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I am the patient. Date of Birth: \_\_\_\_\_ Personal Health #: \_\_\_\_\_  
 (YYYY-MM-DD)

I am representing the patient for the purposes of this complaint and I have completed the [Authorization for Representation](#) form.

My relationship to the patient is: \_\_\_\_\_  
 (Example: *parent, spouse, child, relative, lawyer, friend, physician, executor, Power of Attorney, etc.*)

**PATIENT INFORMATION (If different from above)**

Title: \_\_\_\_\_ Full Name: \_\_\_\_\_  
 (Mr. Ms. Dr. etc.)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (YYYY-MM-DD)

Deceased Personal Health #: \_\_\_\_\_

**CONFIRMATION**

**Please note: All complaints must be signed by the patient and/or patient's representative.**

I have read and understand the following:

I understand that the College of Physicians and Surgeons of British Columbia will obtain relevant medical records of the patient as part of the investigation. The College will share some or all of the information and documents it receives from the complainant and other parties to the physician(s).

The information on this form is collected under the authority of the *Health Professions Act*, RSBC 1996, c.183. The information provided will be used to process your complaint.

If you have any questions about the collection or use of this information, please contact the complaints department at the College of Physicians and Surgeons of British Columbia at 300-669 Howe Street, Vancouver BC V6C 0B4 or by phone at 604-733-7758 or 1-800-461-3008 (toll-free in BC).

**Complainant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (If you are not the patient)

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Complaint Form *continued*

## DETAILS OF THE PHYSICIAN(S)

Please identify the physician(s) you are filing this complaint about, and include an office address, if available. If you are filing a complaint about more than two physicians, please continue on a separate sheet.

**Please note: A copy of this complaint may be sent to the physician(s) you have identified.**

Physician's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Date(s) Attended: \_\_\_\_\_

Occurred at a:     Office                       Hospital                       Other \_\_\_\_\_

Have you tried speaking with this physician about your concern?     Yes             No

Physician's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Date(s) Attended: \_\_\_\_\_

Occurred at a:     Office                       Hospital                       Other \_\_\_\_\_

Have you tried speaking with this physician about your concern?     Yes             No

## RELIEF SOUGHT

Please describe what you would like to see happen as a result of this complaint.

**Please note: The College has no legal authority to direct or influence the payment of financial compensation to complainants.**

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# Complaint Form *continued*

## DETAILS OF OTHER PHYSICIAN(S)

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.

**Please note: A copy of this complaint may be sent to the physician(s) you have identified.**

Physician's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Information Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Information Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## DETAILS OF HOSPITAL(S) / CARE FACILITY(IES) ATTENDED

Please provide the names of the hospital(s) or care facility(ies) and date(s) you attended during this period. If there are more than two hospitals, please continue on a separate sheet.

**Please note: It may be necessary for the College to obtain hospital or facility records as part of the investigation into this complaint.**

Hospital/Care Facility Name: \_\_\_\_\_

City: \_\_\_\_\_ Date(s) Attended: \_\_\_\_\_

Hospital/Care Facility Name: \_\_\_\_\_

City: \_\_\_\_\_ Date(s) Attended: \_\_\_\_\_