Revised May 2021

COMPLAINT FORM

If you wish to make a complaint <u>on behalf of someone else</u> about an interaction with a doctor that concerns you,
please consider contacting the doctor to discuss the issue(s).
If that approach does not help or fit the situation, you can:

1. Contact the College's Complaints Coordinator to discuss your next steps
   OR
2. Use this form to make a formal complaint.

The College reviews all complaints about doctors who practise medicine in Newfoundland and Labrador.

TO MAKE A COMPLAINT ON BEHALF OF SOMEONE ELSE

1. **Complete this form in full and sign the release that applies to you.**
   (A separate form is available for making a complaint on your own behalf.)
2. **Mail or deliver the completed form to the College at the address below.**

Questions about the complaints process?

Contact the College's Complaints Coordinator:
(709) 726-8546
complaints@cpsnl.ca

OUR COMPLAINTS PROCESS

1. We send the doctor a copy of your complaint form, and ask for a response.
2. We send you a copy of the doctor's response.
3. In some circumstances—and with your consent—the College Registrar tries to resolve the complaint.
4. If the Registrar does not resolve the complaint, it goes to the College's Complaints Authorization Committee. Committee members include both doctors and members of the public.
5. The Committee may appoint an investigator to contact people and institutions who have information about your complaint. This may include obtaining copies of personal health records.
6. The Committee reviews all relevant information and meets to discuss and act on your complaint. It notifies you of its decision in writing.

   The Committee has four choices of action:

   - Dismiss the complaint, sometimes with direction to the doctor
   - Caution or counsel the doctor about improvements needed
   - Send the complaint to Alternative Dispute Resolution
   - Instruct the College Registrar to refer the complaint to a hearing.

College of Physicians & Surgeons of Newfoundland and Labrador
120 Torbay Road, Suite W100 • St. John's, NL • A1A 2G8 • cpsnl.ca

I WISH TO MAKE A COMPLAINT ABOUT A PHYSICIAN

MY FULL NAME _____

MY MAILING ADDRESS _____

_____

_____ POSTAL CODE _____

PHONE _____ CELL _____

EMAIL _____

PLEASE CONTACT ME BY . . . ◯ LETTER MAIL ◯ EMAIL

IMPORTANT NOTE:

The College only reviews complaints about physicians. It cannot review complaints about hospitals or non-physicians.

Complaint overview

Please be specific in all the information you provide. Fill out a separate form for each physician you wish to name in your complaint.

PHYSICIAN'S FULL NAME _____

LOCATION OF THE INCIDENT (clinic, hospital, office, etc.) _____

INCIDENT DATE(S) _____

FULL NAME OF PATIENT INVOLVED _____

FAMILY DOCTOR OF PATIENT (full name) _____

Description of the incident / behaviour that concerns you

Please be as detailed as possible. If you need more space, type or write your notes on a separate page and attach them to this complaint form.

The specifics

From your description of the incident (previous page), please indicate the exact action(s) that the doctor did OR did not do that are causing you to make this complaint. This will help the College better understand your concerns.

1. _____
2. _____
3. _____

Witnesses

List any people who may have information about this complaint. Use more paper if needed. You are not required to have a witness to make a complaint.
NOTE: The College may contact each witness as part of the investigation of your complaint.

WITNESS NAME _____

WITNESS CONTACT INFO (phone / email) _____

CONNECTION TO ME/MY COMPLAINT _____
(nurse, family member, receptionist, ...)

HOW THEY WERE INVOLVED _____

Follow-up action

Describe any steps you may already have taken to resolve your complaint.

_____

_____

_____

_____

Preferred outcome(s)

Describe what you hope will happen as a result of making a complaint.
NOTE: The College has no authority to provide financial compensation to complainants. It also cannot direct or arrange patient care.

_____

_____

_____

I confirm that I have read and understand the following:

- I am making a formal complaint against the doctor named in this form.
- The College can investigate this complaint by using relevant personal health records, interviewing witnesses, and by seeking information from other relevant sources.
- The doctor named in this complaint will be sent a copy of this form and all relevant information gathered during the investigation of this complaint.
- If this complaint leads to a hearing—or the Committee's decision is appealed to a court of law—information relating to the complaint must be disclosed and I may be called to testify as a witness.
- If I do not fully complete this form or participate in the investigation, this complaint may be dismissed for lack of information.

SIGNATURE _____

DATE _____

RELEASE FORM A:
ACTING FOR A PATIENT WHO CANNOT ACT FOR THEMSELF

USE THIS FORM IF the patient on whose behalf you are filing this complaint is either:

a) deceased OR

b) unable, due to their age (they are a minor) or capacity (health), to do so on their own behalf

Complainant's Relationship to Patient

PATIENT FULL NAME _____

COMPLAINANT'S RELATIONSHIP TO PATIENT _____
(e.g., parent , executor, ...)

Documentation demonstrating your relationship is <u>required</u> for the following categories: legal guardian, executor, power of attorney. Parents of a patient who is a minor are not required to provide documentation.

Complainant Consent for Information Release

For the purposes of investigating this complaint against a physician on behalf of the patient named herein, I, the undersigned hereby consent and authorize the release of information contained in any of the patient's health records (including but not limited to: hospital and doctor's office records, pharmaceutical records and patient billing information) to the College of Physicians and Surgeons of Newfoundland and Labrador.

PATIENT'S FULL NAME _____

PATIENT'S MCP # _____ PATIENT'S DATE OF BIRTH _____

COMPLAINANT FULL NAME _____

COMPLAINANT SIGNATURE _____ DATE _____

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RELEASE FORM B:
ACTING AT THE REQUEST OF THE PATIENT INVOLVED

USE THIS FORM IF the patient involved in the incident has asked you to be the complainant on their behalf.

NOTE: To protect privacy, the College cannot process a Complaint Form without a signed authorization for a complainant to act on a patient's behalf.

Patient Authorization of Complaint Filing & Information Release

For the purposes of investigating this complaint against a physician, I, the undersigned patient, hereby consent to the complainant named below pursuing this complaint on my behalf. I give them permission to receive all information relating to the investigation of the complaint, including my medical information.

I also hereby consent and authorize the release of information contained in any of my health records (including but not limited to: hospital and doctor's office records, pharmaceutical records and patient billing information) to the College of Physicians and Surgeons of Newfoundland and Labrador.

COMPLAINANT'S FULL NAME _____

PATIENT'S NAME _____

PATIENT'S MCP # _____

PATIENT'S SIGNATURE _____ DATE _____

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RELEASE FORM C:
ACTING ON BEHALF OF A PATIENT'S AUTHORIZED REPRESENTATIVE

USE THIS FORM IF the patient on whose behalf you are filing the complaint is either:

a) deceased OR

b) unable, due to their age (they are a minor) or capacity (health), to do so on their own behalf AND

c) the patient's authorized representative (e.g. parent/executor/power of attorney) has asked for you to file the complaint on their behalf

For the purposes of investigating this complaint against a physician, I, the authorized representative of the patient, hereby consent to the complainant named below pursuing this complaint on my behalf. I give them permission to receive all information relating to the investigation of the complaint, including the patient's medical information.

I also hereby consent and authorize the release of information contained in any of the patient's health records (including but not limited to: hospital and doctor's office records, pharmaceutical records and patient billing information) to the College of Physicians and Surgeons of Newfoundland and Labrador.

PATIENT'S FULL NAME _____

PATIENT'S MCP # _____ PATIENT'S DATE OF BIRTH _____

COMPLAINANT'S FULL NAME _____

AUTHORIZED REPRESENTATIVE'S FULL NAME _____

AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT _____
(e.g., parent , executor, ...)

Documentation demonstrating your relationship is <u>required</u> for the following categories: legal guardian, executor, power of attorney. Parents of a patient who is a minor are not required to provide documentation.

AUTHORIZED REPRESENTATIVE'S SIGNATURE _____ DATE _____

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