College of Physicians and Surgeons of British Columbia
300–669 Howe Street
Vancouver BC V6C 0B4
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. Submit 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 completing this 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

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

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

SUBMISSION

When you have completed this 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

EMAIL complaints@cpsbc.ca
Note: Sending unencrypted records by email attachment is not a secure method of transmission. If you are concerned about your privacy, you may wish to send your correspondence via regular mail or facsimile to the College.

Need help filling this out? Call 604-733-7758 (1-800-461-3008 toll-free in BC) or email complaints@cpsbc.ca.

Thank you for taking the time to complete this form.

PERSON REGISTERING THE COMPLAINT

Title: _____ Last name: _____

Middle name: _____ First name: _____

Address line 1: _____

Address line 2: _____

City: _____ Province: _____ Postal code: _____

Home phone number: _____ Preferred phone number: _____

Preferred pronouns (i.e. she/her, he/him, they/them): _____

◯ I am the patient. Date of birth (YYYY-MM-DD): _____ Personal health number: _____

◯ 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: _____

PATIENT INFORMATION (if different from above)

Title: _____ Last name: _____

Middle name: _____ First name: _____

Address line 1: _____

Address line 2: _____

City: _____ Province: _____ Postal code: _____

Home phone number: _____ Preferred phone number: _____

Date of birth (YYYY-MM-DD): _____ Personal health number: _____

Preferred pronouns (i.e. she/her, he/him, they/them): _____

☐ Deceased

CONFIRMATION

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).

Patient's signature: _____ Date: _____

Complainant's signature (if different from above): _____ Date: _____

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.

Note: A copy of this complaint will be sent to the physician(s) you have identified.

Physician's full name: Bonnie Henry (04679)

Address: Office of the PHO, Ministry of Health, Provincial Health Officer 4th floor-1515 Blanshard St PO BOX 9648 STN PR

City: Victoria Postal code: V8W 9P4 Phone: 250-952-1330

Date(s) attended: March 20, 2020 until now

Occurred at a: ◯ Office ◯ Hospital ◉ Other: Entire Province

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.

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

DETAILS OF YOUR COMPLAINT

Please describe your concern in as much detail as possible. Be sure to include specific information of what occurred between you and the physician(s), and the date and location of the incident(s). Please enclose copies of any documents that you feel would be relevant to your case.

Note: A copy of this complaint will be sent to the physician(s) you have identified.

☐ If needed, continue on a separate sheet. Check here if another sheet is attached.

OTHER INFORMATION

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.

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.

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: _____