

# Complaint Form

## INSTRUCTIONS

If you have a question or concern, we encourage you to first speak with your doctor, the patient advocate at your hospital or a College Public Advisor (1-800-268-7096 ext. 603). Please refer to the CPSO's [Guide to the Complaints Process](#) for assistance and more information.

To make a complaint, you may complete this form electronically, print it out and mail it to the address at the end of this form, or submit it online to [ir@cpsy.on.ca](mailto:ir@cpsy.on.ca).

Once the College has received your complaint, we will aim to contact you within two business days.

We are required to notify the doctor and may provide him/her a copy of your complaint.

### Consent for the release of confidential medical information

The investigator handling your complaint will need relevant personal health information.

The investigator may need to get written consent from you or the patient to get certain records.

## Person Registering Complaint

Last name  First name

Street  Apt#

City  Province  Postal code

Daytime telephone  Alt telephone

Email

I am the patient  I am representing the patient for the purpose of this complaint

Relationship to patient

### Obtaining Records

If you are the patient, your doctor is permitted, under the *Personal Health Information Protection Act, 2004*, to disclose your medical information to the CPSO so it can investigate.

If you are **not** the patient, the patient needs to sign a **consent form** or, if unable to do so, their legal representative may sign this **authorization form** instead. This is necessary before the doctor can provide the patient's personal health records.

### **Patient Information** *if different from the complainant*

Last name	<input type="text"/>	First name	<input type="text"/>		
Street	<input type="text"/>	Apt#	<input type="text"/>		
City	<input type="text"/>	Province	<input type="text"/>	Postal code	<input type="text"/>
Daytime telephone	<input type="text"/>	Alt telephone	<input type="text"/>		
Email	<input type="text"/>				
Date of birth	<input type="text"/>	Date of death (if deceased)	<input type="text"/>		
OHIP #	<input type="text"/>				

**Preferred Mode of Communication**

How would you like the College to communicate with you?

Telephone     E-mail     Regular mail     Fax (if confidential line)

**Doctor(s) You Are Complaining About**

Doctor Name	Address	Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Summary of Concerns**

Please list the key points of your complaint here.

1.

2.

3.

### **Describe Your Complaint**

Please tell us in the box below:

- What happened
- Who was involved
- When and where it happened
- Any other information that may help the CPSO in its review
- What you hope will happen as a result of this complaint

\*If more space is required, please attach additional printed pages.

**Other Information**

Please give the names of any other people who were involved and can provide information.

Name	Contact Information	Their role/why they might have information to contribute

*Please enclose or attach copies of any documents you feel would be relevant to your case. Please list any documents you are providing so that we can be sure we have received everything.*

Supporting Documents:

**By checking this box and submitting, I understand that I am complaining to the College of Physicians and Surgeons of Ontario against a doctor. The doctor will be notified.**

**When you have completed this Complaint Form, please submit it:**

E-MAIL [ir@cpso.on.ca](mailto:ir@cpso.on.ca)  
 or  
 MAIL **The Registrar/CEO**  
 College of Physicians and Surgeons of Ontario  
 80 College Street  
 Toronto ON M5G 2E2