College of Physicians & Surgeons of Alberta

Complaint Form

Instructions:

1. Complete this form with as much detail as possible. *(Please type or print.)*
2. Sign and date the form.
3. Attach any additional documents to support the complaint. *(Patient records, proof of authority, etc.)*
4. Mail the completed original form to us. *(We cannot accept electronic copies.)*

When we receive your form, we will:

- ✓ Review all information received. Further communication with the parties involved may occur.
- ✓ Send a copy of your completed form to the physician(s) listed to obtain a response, as necessary.
- ✓ Contact other individuals and institutions named in your complaint form who may have information relevant to your complaint. They may receive a copy of your complaint form.
- ✓ Provide you with a written response. The physician(s) will also receive a copy.

What we CANNOT do:

- × Give a diagnosis, treatment recommendation, referral, or direct patient care.
- × Offer or influence financial compensation.
- × Help you with concerns or complaints about a health professional who is not an Alberta physician or surgeon. *(Please direct such concerns to the appropriate organization or regulatory authority.)*
- × Resolve complaints without contacting the physician(s) identified.
- × Offer legal advice.

✓ My Checklist

Ensure you include the following:

- ☐ Name & address of the physician(s) involved
- ☐ Detailed description of the complaint
- ☐ Documents that support the complaint *(if applicable)*
- ☐ Contact information so we can reach you
- ☐ Completed Complaint form
- ☐ Signed & dated Consent form
- ☐ Proof of authority, if you are not the patient *(see Patient Details section)*

Send completed form to:

Professional Conduct Department
College of Physicians & Surgeons of Alberta
2700-10020 100 ST NW
Edmonton, AB T5J 0N3

Questions/Need Help?

Visit cpsa.ca or contact a Patient Advocate at 780-423-4764 or toll free at 1-800-661-4689

1. Your contact information:

Ms./Mr./Dr./Etc. _____

First Name _____ Last Name _____

Address _____ City _____ Postal Code _____

Daytime Phone # _____ Other Phone # _____

Email _____ ☐ I agree to receive emails about this complaint

2. Patient details:

Complete section A) if you are the patient or section B) if you are not the patient

A)

☐ **I am the patient (see contact information above)**

Birthdate (day/month/year) _____

AB Health Care # _____

COMPLETE ONLY A OR B

B)

☐ **I am NOT the patient.** I am the patient's _____ (e.g., child, mother, guardian etc.)

Please provide the following **patient information:**

Ms./Mr./Dr./Etc. _____

First Name _____ Last Name _____

Address _____ City _____ Postal Code _____

Daytime Phone # _____ Other Phone # _____

Birthdate (day/month/year) _____ AB Health Care # _____

If applicable, date of death (day/month/year) _____

If you are filing this complaint on behalf of someone else, you may need to submit proof of your authority.

Documentation you are including as proof of authority:

☐ Patient's signature on form ☐ Will ☐ Guardianship Order ☐ Other ☐ None

For more information about authority, please contact a Patient Advocate at 1-800-661-4689.

3. Physician details:

Please provide the following details on the physician(s) you are complaining about. Please note we will send a copy of this complaint form and attachments to the physician(s). We may also ask the medical office/hospital to provide personal identifiable information such as diagnostic, treatment and patient care information. A separate release may be required.

First/Last Name _____ Specialty _____

Name of medical office/hospital _____

Address _____ Phone # _____

Date and location of Incident(s) _____

First/Last Name _____ Specialty _____

Name of medical office/hospital _____

Address _____ Phone # _____

Date and location of Incident(s) _____

First/Last Name _____ Specialty _____

Name of medical office/hospital _____

Address _____ Phone # _____

Date and location of Incident(s) _____

4. Others with firsthand information:

Identify any other individual(s) who provided medical care or may have information about the incident(s) (e.g., family physician, other physician, nurse, office staff or family members). We may contact them for a response and send them a copy of your complaint.

First/Last Name _____

Address _____ Phone # _____

Information details

First/Last Name _____

Address _____ Phone # _____

Information details

First/Last Name _____

Address _____ Phone # _____

Information details

5. Complaint details:

What do you hope will happen as a result of your complaint?

Have you attempted to resolve your complaint directly with the physician(s) involved? ☐ Yes ☐ No

Describe in detail what the physician(s) did or did not do causing you to complain, including **where** and **when** it happened. Please attach copies of any documents that support your complaint. Please note we will send a copy of this form to the physician(s) you identify.

description continued...

Attach additional pages if necessary

Signature of person making complaint

Date signed (day/month/year)

Patient to sign and date below when applicable:

As the patient, **my signature below** is consent for the College of Physicians & Surgeons of Alberta to share information about my complaint to the person completing this form. I understand this information may include personal identifiable information, such as diagnostic, treatment and patient care information.

Patient's signature

Date signed (day/month/year)

Privacy is important to us!

We collect, use and/or disclose your personal information with your consent unless otherwise authorized or required by legislation. As per our *CPSA Privacy Statement*, we collect and use your personal information to do our College work, which is to protect the public and to guide and regulate Alberta physicians.