COMPLAINT FORM

Resident medical record no.: _____ Complaint no.: _____
Subject of the complaint: _____
_____
_____

RESIDENT IDENTIFICATION		
Family name :	First name :	
Date of birth :	Room no.:	Tel. no. :

COMPLAINANT (person filing the complaint)	
Name:	Address:
Tel. (home) :	Tel. (work) :
Relationship with resident (if applicable):	

IDENTIFICATION OF THE PARTY ASSISTING OR REPRESENTING THE COMPLAINANT (if applicable)	
Name:	Address:
Tel. (home) :	Tel. (work) :
Relationship with resident (if applicable):	

SUMMARY OF FACTS

EXPECTED OUTCOME

Date : _____ **Complainant signature :** _____

Date received : _____ Signature of Local Commissioner _____

COMPLAINT FOLLOW-UP
Complaint inadmissible: explanation:
Complaint admissable: due date:_____ (45 days) Complaint forwarded to the Medical Examiner : _____ Date :
File closed on (date):_____