COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

COMPLAINT FORM

As the licensing and governing body for doctors in the province of Nova Scotia, the College of Physicians and Surgeons takes your complaint seriously and will investigate it. Often the complaints process takes several months depending on the complexity of the complaint. If you are complaining about more than one doctor, please complete a separate form for each. Additional forms may be obtained by calling (902) 421-2201 or 1-877-282-7767, or you may photocopy this form.

The Complaint Process. To begin an investigation into your complaint please

- Complete this form (one form per doctor).
- Ensure the consent form signature is witnessed. *You only need to complete this form if you are filing a complaint on behalf of someone else.*
- Forward the completed form(s) to the College's Professional Conduct Department.

If you have any questions or require assistance to complete this form, please contact the Professional Conduct Department, at (902) 421-2201 or 1-877-282-7767 or email us at professionalconduct@cpsns.ns.ca.

INTRODUCTION

Are you the patient? ☐ YES ☐ NO
If no, is the patient deceased? ☐ YES ☐ NO Date of Death _____
If the patient is deceased, did they have a will? ☐ YES ☐ NO

When filing a complaint on behalf of a deceased individual, the College needs to verify the complainant has the authority under the Personal Health Information Act (PHIA) to receive details of the patient's health history and will require a copy of the documentation to authorize the complaint (i.e. will, death certificate, etc.).

If you are not the patient, please see attached Consent Form. It must be signed by the patient or legal guardian. If the patient is deceased, the form must be signed by the executor of the patient's estate. Submit completed form with the complaint.

If the patient died without a will, please contact the College's Public Support Advisor to discuss other options available to you.

COMPLAINANT INFORMATION. Complete if you are filing a complaint on behalf of another individual.
TITLE ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Other (please specify) _____

FIRST NAME	MIDDLE NAME	LAST NAME
PHONE (MOBILE)	PHONE (HOME)	PHONE (WORK)
STREET ADDRESS / PO BOX		APARTMENT NUMBER
CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS		
YOUR RELATIONSHIP TO THE PATIENT		

400 - 175 Western Parkway • Bedford, Nova Scotia B4B 0V1 • www.cpsns.ns.ca
Phone: (902) 422-5823 • Toll-free: 1-877-282-7767 • Fax: (902) 422-5271 • professionalconduct@cpsns.ns.ca

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COMPLAINT FORM

PATIENT INFORMATION. Complete all relevant information.

TITLE ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Other (please specify) _____

FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH (DD/MM/YYYY)	HEALTH CARD NUMBER	
PHONE (MOBILE)	PHONE (HOME)	PHONE (WORK)
STREET ADDRESS / PO BOX (if different from complainant)		APARTMENT NUMBER
CITY	PROVINCE	POSTAL CODE

PHYSICIAN INVOLVED IN COMPLAINT INFORMATION

FIRST NAME	LAST NAME
SELECT ONE: ☐ FAMILY PHYSICIAN ☐ OTHER (ER, SPECIALIST, WALK-IN PHYSICIAN, ETC.)	
ADDRESS WHERE CARE WAS PROVIDED (CLINIC, HOSPITAL, ETC.)	
DATE(S) OF WHEN CARE WAS PROVIDED	
Have your concerns been brought to the doctor's attention? ☐ YES ☐ NO ** You are **not required to inform the doctor of your concerns** prior to making a College complaint, but it is helpful for us to know if the doctor is aware and how the doctor responded to your concerns.*	

OTHER INFORMATION. Please provide details regarding any other healthcare professionals or facilities that provided care related to this complaint.

NAME OF HEALTHCARE PROVIDER / FACILITY	CITY	DATE
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ACTIONS TAKEN.

Have you brought your concerns to other authorities for investigation, such as hospitals or law enforcement? ☐ YES ☐ NO

If yes, to whom? _____

DESCRIPTION. *Please print or type. Attach additional pages if necessary.*

Please explain in your own words the incident in question, including dates or approximate dates.

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COMPLAINT FORM

SUMMARY.

Please provide a brief list in point form outlining the specific concerns related to the care received from the doctor in this complaint.

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•
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•
•

Please attach any relevant information that will assist our investigation into this complaint.

COMPLAINANT SIGNATURE	DATE

If you have any questions or require assistance to complete this form, please contact the Professional Conduct Department, at (902) 421-2201 or 1-877-282-7767, or by email at professionalconduct@cpsns.ns.ca.

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AUTHORIZATION AND CONSENT TO RELEASE OF INFORMATION

Anyone may file a complaint with the College. However, where the complainant is someone other than the patient, the College must respect the patient's privacy and may not provide updates or share any information obtained through the complaint investigation process.

If you wish to file a complaint regarding the care provided to another person and receive updates throughout the complaint investigation process, consent is required in the following circumstances:

- You wish to file a complaint regarding the care provided to an adult patient who has capacity to make decisions regarding their care (**patient consent required**);
- You wish to file a complaint on behalf of your child who may be considered a mature minor (**patient consent required**);
- You wish to file a complaint regarding the care provided to a deceased person and you are not the Executor of the deceased patient's estate (**Executor consent required**). (If you are an Executor, no consent is required.)

* If a deceased patient does not have an Executor, you are encouraged to contact the College to discuss your options.

CONSENT

PATIENT'S SIGNATURE	NAME OF WITNESS (PRINT)

OR

LEGALLY AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT
ADDRESS	PHONE NUMBER
WITNESS SIGNATURE	DATE

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