COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

COMPLAINT FORM

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

HOW TO COMPLETE THIS FORM:

1. **Determine which sections of this form you should complete. You may not have to complete all of the sections.**

   ☐ **I am the patient.**
   If you are the patient, complete ***all sections except Section 2.***

   ☐ **Someone else is the patient.**
   If you are filing a complaint on behalf of another patient, complete ***all sections.***

   ☐ **There is no patient.**
   If there is no patient associated with your complaint, please complete ***sections 1, 4, and 6-10.***

2. **Complete each required section as thoroughly as possible.**
3. **Gather any documents which support your complaint. You can submit supporting documentation by email, fax, or regular mail. Once your forms are completed and your documents are assembled, you are ready to submit your complaint. *Please check here if you will be sending additional documents.*** ☐

SECTION 1: Information about the person filing the complaint

Preferred Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr. ☐ None Preferred ☐ Other (Please specify):

FIRST NAME	MIDDLE NAME	LAST NAME
PREFERRED NAME	PRONOUNS	
EMAIL ADDRESS		
HOME PHONE	WORK PHONE	MOBILE PHONE
FULL MAILING ADDRESS		APARTMENT / SUITE
CITY OR TOWN	PROVINCE	POSTAL CODE

SECTION 2: Information about the patient

Is the patient an adult or a mature minor? ☐ YES ☐ NO Is the patient deceased? ☐ YES ☐ NO
If applicable, what is the date of the patient's death? (DD/MM/YYYY) _____
Preferred Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr. ☐ None Preferred ☐ Other (Please specify):

FIRST NAME	MIDDLE NAME	LAST NAME
PREFERRED NAME	PRONOUNS	YOUR RELATIONSHIP TO THE PATIENT
EMAIL ADDRESS		
HOME PHONE	WORK PHONE	MOBILE PHONE
FULL MAILING ADDRESS		APARTMENT / SUITE
CITY OR TOWN	PROVINCE	POSTAL CODE

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SECTION 3: Patient's identifying information

PATIENT'S DATE OF BIRTH (DD/MM/YYYY)	PATIENT'S HEALTH CARD NUMBER

SECTION 4: Information about the physician involved in the complaint

FIRST NAME	LAST NAME
FACILITY OR CLINIC WHERE CARE WAS PROVIDED	PHONE
HOW LONG HAVE YOU BEEN UNDER THE CARE OF THIS DOCTOR?	
APPROXIMATE DATES OF CARE:	

SECTION 5: Information about other Physicians or Facilities that provided care related to this complaint

NAME OF HEALTHCARE PROVIDER OR FACILITY	
CITY OR TOWN	DATE ATTENDED

SECTION 6: Actions taken

You do not have to discuss your concerns with the doctor or other authorities before making your complaint with the College, but it is helpful to us to know if you have.

Have your concerns been brought to this doctor's attention? ☐ YES ☐ NO

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

If yes, to whom?

SECTION 7: Description

Please explain what happened. Include dates or approximate dates. Attach additional pages if necessary.

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SECTION 8: Witnesses

If there were any witnesses (family, friends, medical / office staff) who witnessed the described incident(s), please provide their contact information below. Please be advised that if this matter is referred to an Investigation Committee, the Committee may contact witnesses to take part in an interview.

WITNESS NAME	WITNESS RELATIONSHIP	WITNESS PHONE NUMBER OR EMAIL
WITNESS NAME	WITNESS RELATIONSHIP	WITNESS PHONE NUMBER OR EMAIL
WITNESS NAME	WITNESS RELATIONSHIP	WITNESS PHONE NUMBER OR EMAIL

SECTION 9: 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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-
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SECTION 10: Disclaimers

Read each of the five statements below and put your initials in the box next to each statement to show your understanding. This step is mandatory for complaint submission.

INITIAL	I declare that I am the person identified as the Complainant on this form.
INITIAL	I acknowledge that the College's complaint process is not anonymous, and that my identity will be disclosed to the physician named in my complaint as directed by the Medical Act.
INITIAL	Should you continue to see your physician while the complaint is being investigated, the College recommends you do not discuss the complaint with the physician. Your physician may choose not to provide care during the investigation of your complaint, based on the guidance of their medical legal insurer. This would include such things as prescription renewals, outstanding referrals, form completion, etc.
INITIAL	Because the physician-patient relationship requires trust and confidence, filing a complaint may result in one or both parties feeling this relationship has broken down. Following the resolution of your complaint, the physician may choose to dismiss you as a patient. Should this occur, the physician must notify you in writing and indicate an end of care date. They must also provide or arrange for care until that date and ensure any outstanding medical investigations or serious medical conditions are followed up.
INITIAL	Any individual involved in the College's complaint process is expected to maintain respectful communication, whether in writing, on the phone, or in person.

I HEREBY CERTIFY that the information which I have provided in this form is complete, true, and correct to the best of my knowledge.

SIGNATURE	**DATE**

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