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 PublicEnquiries@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.*

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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: COMPLAINANT INFORMATION

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

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

SECTION 2: PATIENT INFORMATION

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	PREFERRED 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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400 – 175 Western Parkway, Bedford, NS B4B 0V1 • Tel. (902) 421-2201 • Fax (902) 422-5271

SECTION 3: 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 / 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 your account of the incident. 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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SECTION 10: DISCLAIMERS

Read each of the four 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	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. Your physician can dismiss you as a patient following the resolution of your complaint but must notify you in writing, allow you enough time to arrange for your continuing care, 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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