Centre intégré
de santé
et de services sociaux
de l'Outaouais
Québec

COMPLAINT FORM

PATIENT INFORMATION (REQUIRED)

Full Name: _____ Telephone: ( ) ____ - _____
Date of birth: _____-_____-_____ Hospital Card # (if applicable):_____
Address: _____ Postal Code: _____
Current location (if applicable): _____
(room number or external address)

COMPLAINANT INFORMATION: (*if different from patient*)

☐ Representative (with patient`s authorization) ☐ Other _____ (with patient`s authorization)

Full Name: _____ Telephone: ( ) ____ - _____
Address: _____
Reason for representation (why are you representing):_____
Kinship (if applicable): _____

COMPLAINT: (if more space is needed, attach extra sheets)

Employee name (if applicable) _____ Job Title: _____

Where did the incident occur? (ex. Hospital, CLSC): _____

Which Department: _____

Date of incident: _____

Description of incident (please be as specific as possible and include: time, location, date, physical descriptions):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COMPLAINT (continued)

STATE YOUR EXPECTATIONS IN THE TREATMENT OF THIS COMPLAINT:

DIVULGATION AUTHORIZATION: ☐ **YES**

I hereby authorize the Service Quality and Complaints Commissioner to divulge this complaint to the Head of the concerned Department, only for its examination. Strict confidentiality will be upheld during the entire length of the examination process.

Signature of the Patient or of the Legal Representative

Date

Send this completed form by mail to the Service Quality and Complaints Commissioner at 105, Sacré-Coeur blvd, Gatineau (Québec) J8X 1C5; by fax at 819-771-7611 or by email at commissairesauxplaintes@ssss.gouv.qc.ca .