

## MEDICAL COMPLAINT FORM

Providing a precise and detailed complaint will help the Medical Examiner respond appropriately to your concerns.

To facilitate the examination and ensure an appropriate response, it is **strongly recommended** that you file a separate complaint for each doctor involved.

If you need assistance in writing your complaint(s), you can contact the *Centre d'assistance et d'accompagnement aux plaintes (CAAP) de l'Outaouais* by phone at 819-770-3637 or by email at [info@caap-outaouais.ca](mailto:info@caap-outaouais.ca).

### USER INFORMATION (PERSON RECEIVING CARE AND SERVICES) (\*REQUIRED\*)

\*Full Name: \_\_\_\_\_ \*Telephone: ( ) \_\_\_\_ - \_\_\_\_\_  
 \*Date of birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ \*Hospital Card # (if applicable): \_\_\_\_\_  
 \*Address: \_\_\_\_\_  
 \*Postal Code: \_\_\_\_\_  
 \*Email address: \_\_\_\_\_

### COMPLAINANT INFORMATION: (Person writing the complaint, only if different from user)

Representative (with user's authorization)       Nature of representation: \_\_\_\_\_

Full Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Reason for representation (why are you representing the user): \_\_\_\_\_

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

\*Doctor's name: \_\_\_\_\_

\*Speciality: \_\_\_\_\_

\*Where did the incident occur? (ex. Hull Hospital, CLSC de Gracefield): \_\_\_\_\_

\*Which Department?  
 \_\_\_\_\_

\*Date and time of incident:  
 \_\_\_\_\_

\*Description of incident (Describe in details the incident by answering these questions: Who did what? Where? When? How?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**COMPLAINT (continued)**

**STATE YOUR EXPECTATIONS IN THE TREATMENT OF THIS COMPLAINT: (\*REQUIRED\*)**

**DIVULGATION AUTHORIZATION:**  YES

*Please be advised that the Service Quality and Complaints Commissioner will forward your complaint form to the Office of the Medical Examiner upon reception.*

I hereby authorize the Medical Examiner to divulge this complaint to the concerned doctor, only for its examination. Strict confidentiality will be upheld during the entire length of the examination process. **This complaint form must be signed to be receivable.**

\_\_\_\_\_  
**Signature of the User**

\_\_\_\_\_  
**Date**

**Signature of the Representative**

**Date**

Send this completed form by email at [commissairesauxplaintes@ssss.gouv.qc.ca](mailto:commissairesauxplaintes@ssss.gouv.qc.ca) ; by mail to the Service Quality and Complaints Commissioner at 105, Sacré-Coeur boulevard, Gatineau (Québec) J8X 1C5 or by fax at 819-771-7611. You can also use our online complaint form, found here: <https://ciss-ouataouais.gouv.qc.ca/language/en/users-voice/filing-a-complaint/online-complaint-form/>