COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

T 604-733-7758
TF 1-800-461-3008
F 604-733-3503

300–669 Howe Street
Vancouver BC V6C 0B4
Canada

cpsbc.ca

Complaint Form

We value your submission. Please let us know if you think a physician or surgeon's (registrant's) clinical care or professionalism might put people at risk. It can lead to better health and well-being for all patients.

Please complete the following steps to submit your complaint.

1. Fill out this form.
2. If you are filing a complaint on behalf of the patient, fill out the Authorization for Representation form.
3. Make sure all signatures are authorized and additional documentation is provided.
4. Submit the completed form to the CPSBC complaints and practice investigations department.

We can provide support and help you fill out this form. If you have any questions please call 604-733-7758 (1-800-461-3008 toll-free in BC) or email complaints@cpsbc.ca.

Once we receive your complaint, we will send you a letter explaining the next steps. Keep this letter, as it will have your file number and the name of the employee responsible for your file. This employee is your point of contact throughout the process.

Thank you for taking the time to complete this form.

PATIENT INFORMATION

Title: _____ Last name: _____

Middle name: _____ First name: _____

Pronouns (i.e. she/her, he/him, they/them): _____

Date of birth (YYYY-MM-DD): _____ Personal health number: _____

Address line 1: _____

Address line 2: _____

City: _____ Province: _____ Postal code: _____

Email address: _____ Preferred phone number: _____

May messages be left on your voice mail? ◯ Yes ◯ No

Do you identify as First Nations, Inuk/Inuit and/or Métis? (Select all that apply)

☐ Yes, First Nations ☐ Yes, Inuk/Inuit ☐ Yes, Métis ☐ No ☐ Do not know ☐ Prefer not to answer

Racism towards Indigenous people is a problem in BC's health-care system. CPSBC is committed to helping stop this racism and would like to collect Indigenous identity data to identify, monitor and address inequities that result from bias and racism. This data will be used to help improve the quality of health care Indigenous people receive.

PERSON SUBMITTING THE COMPLAINT

Only fill out this section if you are submitting a complaint on behalf of the patient

☐ I am the patient—**please continue to the Confirmation section.**

Title: _____ Last name: _____

Middle name: _____ First name: _____

Pronouns (i.e. she/her, he/him, they/them): _____ ☐ Prefer not to say

Address line 1: _____

Address line 2: _____

City: _____ Province: _____ Postal code: _____

Email address: _____ Preferred phone number: _____

May messages be left on your voice mail? ◯ Yes ◯ No

Preferred method for receiving correspondence: ◯ Email ◯ Mail

Relationship to the patient: _____

Have you completed the Authorization for Representation form? ◯ Yes ◯ No

Is the patient deceased? ◯ Yes ◯ No

CONFIRMATION

Note: All complaints must be signed by the patient and/or patient representative.

I have read and understand the following:

- I understand that the College of Physicians and Surgeons of British Columbia will obtain relevant medical records of the patient as part of the investigation. CPSBC will share some or all of the information and documents it receives from the patient/patient representative and other parties with the registrants.
- The information on this form is collected under the authority of the *Health Professions Act*, RSBC 1996, c.183. The information provided will be used to process my complaint.
- If I have any questions about the collection or use of this information, I can contact the complaints and practice investigations department by phone at 604-733-7758 or 1-800-461-3008 (toll-free in BC), or by mail at 300–669 Howe Street, Vancouver BC V6C 0B4.

Patient signature: _____ Date: _____

Patient representative signature: _____ Date: _____

DETAILS OF THE REGISTRANTS

Please identify the registrants you are filing this complaint about, and include their office address if you have this information.

Registrant information can be found in the registrant directory.

Note: A copy of this complaint will be sent to the registrants you have identified.

Registrant's full name: ______________________________

Address: ______________________________

City: ______________ Postal code: ______________ Phone: ______________

Dates attended: ______________________________

Occurred at a: ◯ Office ◯ Hospital ◯ Other: ______________

Registrant's full name: ______________________________

Address: ______________________________

City: ______________ Postal code: ______________ Phone: ______________

Dates attended: ______________________________

Occurred at a: ◯ Office ◯ Hospital ◯ Other: ______________

Registrant's full name: ______________________________

Address: ______________________________

City: ______________ Postal code: ______________ Phone: ______________

Dates attended: ______________________________

Occurred at a: ◯ Office ◯ Hospital ◯ Other: ______________

Registrant's full name: ______________________________

Address: ______________________________

City: ______________ Postal code: ______________ Phone: ______________

Dates attended: ______________________________

Occurred at a: ◯ Office ◯ Hospital ◯ Other: ______________

☐ Continue on a separate sheet if needed. Check this box if another sheet is attached.

DETAILS OF YOUR COMPLAINT

Please describe your concern in as much detail as possible. Be sure to include specific information of what occurred between you and the registrants, and the date and location of the incident if you have this information. Please include copies of any documents that you feel would be relevant to your complaint.

Note: A copy of this complaint will be sent to the registrants you have identified.

☐ Continue on a separate sheet if needed. Check this box if another sheet is attached.

Please describe what you would like to see happen as a result of this complaint

HOSPITAL/CARE FACILITY INFORMATION

Please provide the names of the hospitals or care facilities you attended during this period, and include dates if you have this information.

Note: It may be necessary for CPSBC to obtain hospital or facility records as part of the investigation into this complaint.

Hospital/care facility name: _____

City: _____ Dates attended: _____

Hospital/care facility name: _____

City: _____ Dates attended: _____

☐ Continue on a separate sheet if needed. Check this box if another sheet is attached.

SUBMISSION

Please complete the checklist below and submit the form and supporting documentation to:

MAIL Complaints and Practice Investigations
College of Physicians and Surgeons of BC
300–669 Howe Street
Vancouver BC V6C 0B4

FAX 604-733-3503

EMAIL complaints@cpsbc.ca
Note: Sending unencrypted records by email attachment is not a secure method of transmission. If you are concerned about your privacy, you may wish to send your correspondence via regular mail, courier or fax to the College.

CHECKLIST – Have you completed the following?

- ☐ included the full names and addresses of the registrants involved
- ☐ described the complaint in as much detail as possible
- ☐ enclosed copies of documents that may support this complaint
- ☐ provided your name and a telephone number where you can be reached during the day
- ☐ signed and dated Authorization for Representation form, if applicable
- ☐ signed and dated the Confirmation section (page 2)
- ☐ checked that all pages of this form are filled in and any separate sheets are attached

CPSBC ROLE

What we can do

- review a physician or surgeon's care and conduct to determine if they met the CPSBC practice standards
- provide a range of remedial and disciplinary measures to help the physician or surgeon improve their practice

What we cannot do

- direct the clinical care of patients
- transfer a patient's care to another physician or surgeon
- compel a physician or surgeon to apologize
- provide or insist on financial compensation
- overrule opinions given in independent medical examinations (e.g. independent medical examinations for WorkSafeBC, ICBC)
- keep a complainant's identity anonymous