

The College of Physicians & Surgeons of Nova Scotia

As the licensing and governing body for physicians in the province of Nova Scotia, the College takes your complaint seriously and will investigate it. Often the complaints process takes several months depending on the complexity of the complaint. If you are complaining about more than one physician, please complete a separate form for each. Additional forms may be obtained by calling 422-5823 or 1-877-282-7767, or you may photocopy this form.

The Complaints Process:

To begin an investigation into your complaint please

- **Complete this form (one form per physician)**
- **Ensure the consent form signature is witnessed**
- **Forward the completed forms to the College's Investigations Department**

If you have any questions or require assistance to complete this form, please contact the Investigations Department, at 422-5823 or 1-877-282-7767.

1. Patient information

Ms/Mrs/Mr/Dr _____ Address _____
Last Name _____
Given Name _____
Birth Date _____ Tel. Home _____
Health Card # _____ Tel. Work _____

2. Person making the complaint:

Same as Above (#1)

OR

Relationship to patient _____
Ms/Mrs/Mr/Dr _____ Address _____
Last Name _____
Given Name _____
Tel. Home _____
Tel. Work _____

(If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing the complaint. Examples include: executor of an estate, legal guardian, patient's written consent, etc.)

3. Consent for release of information.
(Inserted form)

Complete this form by providing the appropriate information and signatures. A witness is any adult person who can confirm that he/she saw you sign the form.

4. Print full name of the doctor complained about along with his/her address and telephone number.

Physician Name	Address	Telephone Number

5. How long have you been a patient of this doctor? _____

**6. Have you brought your concerns to this doctor’s attention? Yes ___ No ___
 Please explain.**

7. Provide the full name of any other individual(s) and the details of the information they may have pertaining to your complaint (e.g., other doctor, therapist, chiropractor).

Name	Address	Information details

8. Provide full names of hospitals and dates you attended, related to your complaint, if applicable.

Name of Hospital	City	Date(s) attended

9. My complaint is about: (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Quality of care | <input type="checkbox"/> Inappropriate comments or conduct |
| <input type="checkbox"/> Medical records or medical reports | <input type="checkbox"/> Impaired physician |
| <input type="checkbox"/> Independent medical exams (IME’s or IDME’s) | <input type="checkbox"/> Communication problems |
| <input type="checkbox"/> Other: _____ | |

