College of
HEALTH AND CARE
PROFESSIONALS OF BC

Complaint Form

Members of the public — and, in some cases, licensees — may use this fillable form to submit a complaint against a CHCPBC licensee. For details on the types of complaints CHCPBC can address and the complaint process, please visit **the College website**. To confirm that the individual who your complaint is about is a CHCPBC licensee, please check the **CHCPBC Public Registry**.

All fields are required unless otherwise noted.

If you have questions about completing this form or need assistance, please contact us:

- Phone: 604-742-6715 or 1-877-742-6715 (toll-free)
- Email: **complaints@chcpbc.org**

Licensee

Who is the complaint about?

Last Name: _____

First Name: _____

Profession: _____

Practice Location(s): _____

Complainant

Who is making the complaint?

Last Name: _____

First Name: _____

Pronouns (optional): _____

Mailing Address: _____

Email: _____

Phone: _____

Communication Needs/Preferences

☐ I require an interpreter. Language: _____

Preferred contact method: ☐ Email ☐ Phone ☐ Mail

Can we leave a voicemail? ☐ Yes ☐ No

Context

What is your relationship to the licensee/situation?

☐ **Patient:** I received health services from the licensee.

☐ I identify as Indigenous - First Nations, Inuk/Inuit or Métis (optional).

Racism against Indigenous Peoples is a serious problem in BC's healthcare system. To help identify and address inequities and improve the safety and quality of care Indigenous Peoples receive, we invite individuals to voluntarily self-identify as First Nations, Inuit, or Métis. This information supports our efforts to provide a culturally safe complaints process.

☐ **Representative:** I am submitting this complaint on behalf of the patient.

Patient's Last Name: _____

Patient's First Name: _____

☐ I completed an **Authorized Representative Form** confirming I can act on behalf of the patient.

☐ **Other:** _____

Complaint

Does the complaint allege any of the following? Select all that apply.

☐ Discrimination

☐ Harm (includes financial abuse, emotional abuse, neglect, or physical abuse)

☐ Sexual abuse or sexual misconduct

☐ None of the above

Where did the incident(s) occur?

Location Type: ☐ Clinic / ☐ Hospital / ☐ In-Home Care / ☐ Outpatient Facility / ☐ Other

Location Name: _____

City/Municipality: _____

When did the incident(s) occur?

Single date: _____

Multiple dates: _____

What happened?

Please describe the incident(s) in as much detail as possible.

If your complaint relates to discrimination, sexual abuse, or sexual misconduct, and you have already provided a detailed written account of the incident(s) to another organization or party, you do not need to repeat it. With your consent, we can request a copy of that information on your behalf to avoid unnecessary re-telling. Please provide the name and contact information of the organization or party below.

If you require more room, please attach a separate page.

Have you raised this complaint with anyone else in a position to resolve the matter (the licensee, their employer, police, or other)?

☐ No

☐ Yes – Details: _____

Attachments

Attach any documents you would like us to review. If applicable, please include a completed copy of the **Authorized Representative Form**.

Privacy

☐ I understand the information on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act* (FIPPA) and the *Health Professions and Occupations Act* (HPOA).

☐ I understand the information provided will be used and disclosed, as permitted by law (including FIPPA and HPOA), to process the complaint.

Submit

You may submit the completed form by:

- **Email:** complaints@chcpbc.org
- **Fax:** 604-608-9863
- **Mail:** 900-200 Granville Street, Vancouver, BC V6C 1S4