

COMPLAINT FORM

COUNCIL FOR PROFESSIONS SUPPLEMENTARY TO MEDICINE

(A Statutory Body under the Ministry of Health & Environment)

Please print, complete & submit to:

Council for Professions Supplementary to Medicine
9th Floor Oceana Complex
2-4 King Street
Kingston

DISCLAIMER: The names and address of complaints filing.

The Council declares that reports of misconduct, bodily harm, provided in this report will be held in strict confidence and used solely for investigating the statements provided therein.

1. TO BE COMPLETED BY COMPLAINANT

NAME: (Mr. Mrs. Miss) _____

ADDRESS: _____

TEL Nos. _____ **Cel:** _____

2. PERSON AGAINST WHOM

NAME: (Mr. Mrs. Miss) _____

TYPE OF PRACTICE: _____

ADDRESS OF PRACTICE: _____

TEL Nos: _____ **Cel:** _____

COMPLAINT:

Please describe your complaint as completely as you can. Sign and date the Form.

Patients Name: (Mr. Mrs. Miss) _____

Date of Birth: (mm/dd/yyyy) ____/____/____

When incident occurred: _____

Where did this happen _____

Were you referred? If yes by whom _____

Any Witness? State Names _____

Description of incident:

Signature: _____

Date: _____

