

The information you provide here is  
protected and will remain confidential

A complaint may be filed by any user or his/her representative. However, a complaint against a physician, dentist, pharmacist or resident may be filed by any other person. Please check the status of the person filing this complaint:

- User                       Representative                       Other (please explain): \_\_\_\_\_

**USER'S IDENTIFICATION**

First Name and Surname: \_\_\_\_\_ Tel.: Res. \_\_\_\_\_ Room \_\_\_\_\_

Date of birth: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal code: \_\_\_\_\_

Place where user may be reached within the establishment (Room No./Ext.): \_\_\_\_\_

**IDENTIFICATION OF USER'S REPRESENTATIVE, IF APPLICABLE**

Status of user's representative:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Holder of parental authority | <input type="checkbox"/> Spouse  | <input type="checkbox"/> Heir or legal representative of a deceased user                             |
| <input type="checkbox"/> Tutor                        | <input type="checkbox"/> Close relative  | <input type="checkbox"/> Person with special interest in the user of full-age under legal incapacity |
| <input type="checkbox"/> Private curator              | <input type="checkbox"/> An authorized person mandated by the incapable user of full-age before his incapacity |  |
| <input type="checkbox"/> Public curator               |  |  |

First name and surname: \_\_\_\_\_ Tel.: Res. \_\_\_\_\_ Room \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal code: \_\_\_\_\_

If user is assisted in filing the complaint, the assisting person's identification is required (e.g., CAAP, rights agency, etc.)

Name: \_\_\_\_\_ Tel.: Res. \_\_\_\_\_ Bur. \_\_\_\_\_

**IDENTIFICATION OF ENTITY AFFECTED BY YOUR COMPLAINT**

(Hospital, CLSC, CHSLD, etc.)

Name of entity: \_\_\_\_\_

**WHAT IS THE REASON FOR YOUR COMPLAINT? (if space is insufficient, please attach another sheet)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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