COMPLAINT FORM

YUKON MEDICAL COUNCIL ONLY	
File Number:	
Physician Number:	**Date received/active:** (date stamp)

This form must be legible to be reviewed by Council. To complete this form please either type or print in dark blue or black ink. The fully completed form is required to perform a full investigation into your complaint.

SECTION A - COMPLAINANT / PATIENT INFORMATION

I am the patient and complainant

I am making a complaint on behalf of the patient

PATIENT INFORMATION	
First Name	Last Name
Mailing Address	
City	Postal Code
Email Address	
Daytime Phone	Fax Number
Date of Birth	

COMPLAINANT INFORMATION (fill out only if you are not the patient)	
First Name	Last Name
Mailing Address	
City	Postal Code
Email Address	
Daytime Phone	Fax Number
Relationship to Patient	Status of Patient

SUBMIT COMPLETED COMPLAINT FORM IN THE FOLLOWING WAYS
Email: ymc@gov.yk.ca • Mail: Box 2703 (C-18), Whitehorse, YT Y1A 2C6 • In person: 307 Black Street, Whitehorse
Questions? Email or call 867.667.3774 or 800.661.0408. ext.3774

COMPLAINT FORM

If the incident(s) involved more than one physician you may include the physician information and complaint details within one submission. Complaints with multiple physicians identified will be treated as individual complaints. Yukon Medical Council does not have the authority to investigate the practices of a clinic or institution; only the practice of physicians.

For multiple physicians please complete "Physicians Information" for each physician you wish to file a complaint against. If you are filing a complaint against four or more physicians please complete and print this page as required. A copy of your submitted complaint will be sent to the physicians listed below only if Council requests a physician response.

SECTION B - PHYSICIAN INFORMATION

Complaint against one Physician   Complaint against multiple physicians

1. PHYSICIAN	
First name	Last Name
Place of Practice	
Phone Number	City

2. PHYSICIAN	
First name	Last Name
Place of Practice	
Phone Number	City

3. PHYSICIAN	
First name	Last Name
Place of Practice	
Phone Number	City

YUKON MEDICAL COUNCIL

COMPLAINT FORM

Resolving a complaint is achieved by understanding the situation and circumstances surrounding the issue from both the complainant's perspective and the perspective of the physician. Submitted complaints are researched and investigated thoroughly to ensure quality health care. Please provide as much information as possible to make sure the matter is clearly explained.

SECTION C – COMPLAINT DETAILS

Occurred at   Office   Hospital   Other

1. Nature of Complaint (check all that apply)	Quality of Care Medical Reports or Records Inappropriate Comments or Conduct	Prescribing Other:

2. Provide the full name of any other individual(s) who may have information regarding this complaint. Please include the details of the information they may have about your complaint. For example, other physician, therapist, witness(s) who were present, as well as their contact information.

Additional Information attached?   Yes   No

Name	Contact Information	Information Details

3. If your complaint involves care you received in a hospital or institution provide the name(s), location and date(s) you attended

Name	City	Date(s) attended

SUBMIT COMPLETED COMPLAINT FORM IN THE FOLLOWING WAYS
Email: ymc@gov.yk.ca • Mail: Box 2703 (C-18), Whitehorse, YT Y1A 2C6 • In person: 307 Black Street, Whitehorse
Questions? Email or call 867.667.3774 or 800.661.0408. ext.3774

4. In your own words provide a summary of the events and interactions surrounding the incident(s) leading to the complaint.

Additional Page provided (next page)

YUKON MEDICAL COUNCIL

COMPLAINT FORM

Summary of incident/events continued…

Additional information attached? Yes No

SUBMIT COMPLETED COMPLAINT FORM IN THE FOLLOWING WAYS
Email: ymc@gov.yk.ca • Mail: Box 2703 (C-18), Whitehorse, YT Y1A 2C6 • In person: 307 Black Street, Whitehorse
Questions? Email or call 867.667.3774 or 800.661.0408. ext.3774

5. Have you tried to resolve this by speaking the physician about your concern? Yes No

Details of what the physician said/did to address your concerns:

Additional information attached? Yes No

SECTION D – ADDITIONAL INFORMATION / ATTACHEMENTS

Please include any supporting / relevant documentation that will assist our inquiry into this complaint.

Identify what attachments are included and how many pages.

Attached documents? Yes No

Item	Description	Number of Pages

YUKON MEDICAL COUNCIL

COMPLAINT FORM

SECTION E – CERTIFICATION

1. I have read and understand the information provided regarding the lifecycle of the complaint and the guidance document to assist me in filling out the complaint form
2. I understand that I am making a complaint about the physician(s) identified in Section B of this form
3. I understand the personal information contained on this form is collected under the *Medical Professions Act* and will be used only for the purpose of responding to my complaint.

_____________________________________ _____________________________________

Complainant Signature   Date Signed

*complainant identified in Section A of this form

SECTION F – AUTHORIZATION FOR RELEASE OF INFORMATION

1. I understand my signature on the release will allow the Yukon Medical Council where applicable to:
   a. Provide a copy of the complaint to the appointed investigator for the purposes of investigation;
   b. Obtain medical records or other information, as specified in my complaint relevant to my complaint issue(s). Medical records include person-identifiable information, diagnostic, treatment and care documentation;
   c. Provide a copy of my complaint to the physician(s) identified in **Section B** of this form should the Yukon Medical Council make the decision to receive a response from the physician(s) regarding this complaint;
   d. Disclose where applicable, information concerning my complaint including person identifiable information, diagnostic, treatment and care information to the person making the complaint on my behalf;
   e. Use this original form for faxing / photocopying to collect information from physicians and facilities and the copy of this form shall be as valid as the original

   In order to investigate certain matters under the Medical Professions Act.

2. This will authorize the release of records, including medical information or otherwise concerning the patient identified in **Section A** of this form
3. I understand why I have been asked to consent to the disclosure of this information. I also understand that this consent is valid for a two-year period past the date the complaint was submitted and that I may revoke this consent in writing at any time.

_____________________________________ _____________________________________

Signature of Patient or Legal Representative *   Date Signed

_____________________________________ _____________________________________

Signature of witness   Date signed

Print Name of Witness:_____________________________________

*if you are the legal representative of the patient, you must provide legal documentation authorizing your signature. Examples include: executor, administrator of an estate, legal guardian, person with power of attorney, or patient's written consent etc.

SUBMIT COMPLETED COMPLAINT FORM IN THE FOLLOWING WAYS

Email: ymc@gov.yk.ca • Mail: Box 2703 (C-18), Whitehorse, YT Y1A 2C6 • In person: 307 Black Street, Whitehorse
Questions? Email or call 867.667.3774 or 800.661.0408. ext.3774