Patient Complaint Reporting Form

Canadian Memorial Chiroptactic College

CMCC

Patient Name:	
Address:	
City:	Province:
Postal Code:	
Telephone # day:	Telephone # evening:

Intern:
Clinician:

What is the nature of your complaint?

Please provide the details of the nature of your complaint including what your intern or clinician did or failed to do leading to your complaint.

How can we help?

What do you hope will happen as a result of your complaint?

Return form to:

By mail:
Patient complaint resolution program
CMCC Campus Clinic
6100 Leslie Street
Toronto, Ontario M2H 3J1

By phone or fax:
Susan Rutherford
Phone number: 416 482 2340 ext. 109
Fax number: 416 646 1115

_____
Signature of Complainant

_____
Date Signed