Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec
Commissaire aux plaintes et à la qualité des services

CONFIDENTIAL

COMPLAINT FORM

This form can be completed online at the following address: santeestrie.qc.ca/complaint

IDENTIFICATION OF THE USER *(REQUIRED)*	**IDENTIFICATION OF THE COMPLAINANT** *(IF DIFFERENT FROM USER)*
Last name:	Last name:
First name:	First name:
Pronoun used: ☐ he ☐ she ☐ they	Pronoun used: ☐ he ☐ she ☐ they
Date of birth:	Address:
User deceased ☐	City:
Address:	Postal code:
City:	Phone number:
Postal code:	Cell. number:
Phone number:	E-mail:
Cell. number:	No E-mail ☐
E-Mail:	
No E-Mail ☐	
Hospital card number (if known):	

IF YOU FILE A COMPLAINT FOR A USER, YOU DO SO IN WHAT CAPACITY?

☐ I am the legal representative of a user of full age **unable to give consent**:

- ☐ TUTOR
- ☐ HOMOLOGATED MANDATE
- ☐ OTHER *(PLEASE SPECIFY)*:

☐ I am the parent of a minor child

☐ I am assisting the user **capable of giving** consent to file his/her/their complaint.
Specify relationship to the user:_____

The user capable of giving consent must be aware of this complaint initiative and approve it.

The complaint will be under the user's name and he/she/they will receive the conclusion, unless otherwise specified by he/she/they.

I hereby authorize that the integral copy of this complaint form be sent to the manager concerned (when needed)**:**
☐ YES ☐ NO

Note: for medical complaints, the physician concerned by the complaint will receive copy of this form in conformity with the article 47 of the Act respecting Health Services and Social Services.

SEND THIS COMPLETED FORM TO:

Commissaire aux plaintes et à la qualité des services
CIUSSS de l'Estrie – CHUS
CLSC Murray
500, rue Murray, case postale 2
Sherbrooke (Québec) J1G 2K6

by fax: 819 822-6716
by E-mail: plaintes.ciussse-chus@ssss.gouv.qc.ca
by phone: 1 866 917-7903 (toll-free)

LOCATION WHERE THE INCIDENT OCCURED					
☐ **CLSC**	☐ **CHSLD**	☐ **HOSPITAL**	☐ **READAPTATION CENTER**	☐ **RÉSIDENCE PRIVÉE POUR AÎNÉS (RPA)**	☐ **AUTRE**
Name of the installation:					
City:					
Employee's name (if applicable):					
Physician's name (if applicable):					

DATE AND TIME OF THE INCIDENT *(IF APPLICABLE):*

DESCRIPTION OF THE INCIDENT

EXPECTED RESULTS