

Complaint Form

The College of Physiotherapists of New Brunswick (CPTNB) investigates complaints about New Brunswick physiotherapists. Information collected on this form and in the complaint process is collected under the authority of the Physiotherapy Act (N.B.). Information is handled in confidence and used to process your complaint.

While we have the authority to investigate concerns and to discipline our members, financial compensation is a matter determined in civil court. We cannot direct a physiotherapist to provide you with any financial compensation. Seek legal advice if financial compensation is a concern.

PRINT/TYPE ONLY, PLEASE

My information [the complainant]

Title (Mr., Mrs., Ms.)	Name (First, Last)		
Street or mailing address			
City	Province	Postal Code	Daytime phone number
Email address			

Representative information

If you are completing this form on behalf of the complainant, provide your details, the complainant's signature and/or authorizing documentation if applicable (e.g. proof of legal guardianship).

Title (Mr., Mrs., Ms.)	Name (First, Last)		
Street or mailing address			
City	Province	Postal Code	Daytime phone number
Relationship to the complainant			
If applicable, name of authorizing document(s)			

 Complainant's signature

My complaint is about/involves [check all that apply]

- | | | |
|--|---|--|
| <input type="checkbox"/> Assessment/treatment | <input type="checkbox"/> Confidentiality/privacy | <input type="checkbox"/> Patient care |
| <input type="checkbox"/> Billing/financial | <input type="checkbox"/> Management of patient care | <input type="checkbox"/> Record keeping/charting |
| <input type="checkbox"/> Clinic cleanliness/safety | <input type="checkbox"/> Office staff/support personnel | <input type="checkbox"/> Sexual impropriety |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Other _____ | |

Information about the physiotherapist(s)

CPTNB will send a copy of your complaint to the individual(s) listed.

Physiotherapist's name

Daytime phone number

Address

Physiotherapist's name

Daytime phone number

Address

Physiotherapist's name

Daytime phone number

Address

Information about other individuals who may have information relevant to this complaint

CPTNB may send a copy of your complaint to the individual(s) listed.

Name

Contact details

Information they may have

Name

Contact details

Information they may have

Name

Contact details

Information they may have

My complaint involves care received in the hospital, facility or clinic noted below

CPTNB may ask these facilities to provide patient information, treatment records and diagnostic reports.

Facility name

Date(s) attended

Address

Facility name

Date(s) attended

Address

Facility name

Date(s) attended

Address

My complaint

Include specifics about what caused your complaint (what the physiotherapist did or did not do, dates, locations, etc.). If possible, list information, dates, etc. in the order they happened. Mention and include, any relevant documents. A copy of your complaint will be sent to the physiotherapist(s) noted in the your complaint.

[illegible]

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

☐ I could not describe my complaint in the space provided so I am including (a) separate page(s).

☐ I have enclosed other documents related to my complaint.

All complaints must be signed by the complainant and/or complainant's representative.

Date _____

Date _____

Print, sign and then mail or fax the Complaint Form and any supporting documentation to:

Fax: 506-849-9779