



# COLLEGE OF OPTOMETRISTS OF BRITISH COLUMBIA <sup>96</sup>

906 – 938 Howe Street, Vancouver, BC V6Z 1N9

Ph. 604-623-3464 Fax:604-623-3465

[www.optometrybc.com](http://www.optometrybc.com)

Please complete the following form which must be signed (on page three) in order to submit it to the College.

## FOR OFFICE USE ONLY

Registrant's Last Name \_\_\_\_\_

Registrant's First Name \_\_\_\_\_

Complaint received:

Action taken: \_\_\_\_\_

## PATIENT REGISTERING COMPLAINT

Title:      Mr.      Ms.      Mrs.      Dr.      other

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Middle initial: \_\_\_\_\_

Home Phone

Business Phone

Cell Phone (optional)

Fax number (optional)

Email (optional)

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

I, hereby authorize \_\_\_\_\_

Insert name of registrant ( or other third party from whom disclosure is required)

to release my personal information and medical and other records to the College of Optometrists of British Columbia (the "College" ) for use in an investigation regarding this complaint under s. 33 of the *Health Professions Act*, RSBC 1996, c. 183.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**REPRESENTATIVE INFORMATION:** If you are completing this form on the Complainant's behalf, please provide the following information:

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Relationship to Complainant: \_\_\_\_\_

**CONSENT FOR REPRESENTATIVE:** If you are the representative, please have the Complainant (or next of kin or executor) sign the following declaration to give you permission to act on their behalf:

I, hereby give (Representative's name) \_\_\_\_\_  
permission to file this complaint and represent me with respect to this complaint.

Complainant's Signature:  
or Next of Kin or Executor

Date: \_\_\_\_\_

Representative's Signature:

Date: \_\_\_\_\_

## COMPLAINT REGISTERED AGAINST

**IMPORTANT:** Please identify the optometrist(s) you are filing this complaint about, along with his/her office address, if you know it. Please describe your concern in as much detail as possible and ensure to include specific information of what occurred between you and the optometrist(s), and the date and location of the incident(s). Please enclose copies of any documents that you feel would be relevant to your case.

Please note: A complete copy of your complaint with attachments will be forwarded to the optometrist for a response.

Optometrist's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**DETAILS OF COMPLAINT** (please describe the nature of your complaint including dates and locations of contact)

If you require additional space, please continue on a separate sheet and attach it to this form.  
**Check here** if you have continued on another sheet and number your pages.

If you are filing a complaint about more than one optometrist, please continue on a separate sheet.

**Please note:** All complaints must be signed by the Complainant or the Complainant's authorized representative.

The information on this form is collected under the authority of the *Health Professions Act*, RSBC 1996, c.183. The information which you provide will be used for the purpose of completing an investigation under Part 3 of the *Health Professions Act*. If you have any questions or concerns regarding the collection, use or disclosure of this information, please contact the Registrar at the College of Optometrists of British Columbia (Suite 906, 938 Howe Street, Vancouver, BC V6Z 1N9).

Complainant's Signature:

Date: \_\_\_\_\_

Representative's Signature:

Date: \_\_\_\_\_

**DETAILS OF OTHER OPTOMETRIST(S):** Please identify any other optometrist(s) or other health provider(s) who provided you with medical care relevant to your concerns.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
Print name Insert name of registrant or other third party from whom disclosure is required

to release my personal information and medical and other records to the College of Optometrists of British Columbia (the "College" ) for use in an investigation of this complaint under s. 33 of the *Health Professions Act*, RSBC 1996, c. 183.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Optometrist or other health provider's name: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Information Details:

You will receive a letter from the College acknowledging receipt of the complaint and confirming that it has been referred to the Inquiry Committee for an investigation. The length of the investigation process will depend on a number of factors including the nature of the allegations and number of individuals involved.

### **CHECKLIST**

Have you:

- included the name(s) and address(es) of the optometrist(s) involved
- described the relevant details of the complaint
- enclosed copies of any relevant documents that may support this complaint
- provided your name and a telephone number where you can be reached during business hours
- signed and dated the *Complainant's Consent for Representative* section, if applicable
- signed and dated the *Details of Your Complaint*
- checked that all four pages of this form have been completed and that any additional sheets are attached

**Please send the completed form to:**

The attention of the Registrar of the College of Optometrists of BC 906  
906-938 Howe Street  
Vancouver, BC, V6Z 1N9  
Tel: (604) 623-3464  
Fax: (604) 623-3465

**Thank you for taking the time to complete this form.**