COLLEGE OF OPTOMETRISTS OF BRITISH COLUMBIA

906 – 938 Howe St. Vancouver, BC V6Z 1N9
604-623-3464 college@optometrybc.ca

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)

Email (optional)

Address: _____

City: _____ Province: _____ Postal Code: _____

I, hereby authorize _____

Insert name of registrant (Optometrist 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, optometrist or other third party from whom

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
Email: college@optometrybc.ca

Thank you for taking the time to complete this form.