

The College of Dental Hygienists of Prince Edward Island (CDHPEI) requests the completion of this form when filing a complaint.

By completing this Complaint Form you:

1. Acknowledge that you are lodging a written formal complaint and understand that the College will investigate all written formal complaints; and
2. Give permission to the College to access your records, and to request and receive copies of all medical and related records related to the complaint; and
3. Give permission to the College to discuss and/or release part or all of the Complaint Form and all supporting documentation with any person(s) named in the complaint, or any person(s) deemed necessary in the investigation of the complaint; and
4. Certify that the details and information provided are true, accurate and complete to the best of your knowledge.

If you have any questions concerning the above, require assistance, or would like to speak with College staff before completing this complaint, please contact the CDHPEI.

**Complainant Information**

<b>PERSON FILING COMPLAINT</b>			
Name	<input type="text"/> <small>GIVEN NAME(S), INITIAL(S)</small>	<input type="text"/> <small>LAST NAME</small>	
Address	<input type="text"/> <small>STREET NUMBER - STREET NAME - APT. /UNIT NUMBER</small>	<input type="text"/> <small>CITY / COMMUNITY</small>	<input type="text"/> <small>PROVINCE</small> <input type="text"/> <small>POSTAL CODE</small>
Phone	<input type="text"/>	Email	<input type="text"/>

*If you are not the client or the person directly involved in the incident, please describe your relationship to that individual (parent, spouse, child, relative, health professional, lawyer or friend):*

Relationship to Client

*Please be advised that if you are filing a complaint on behalf of another individual, the College may require the individual to provide consent to access personal information relating to the complaint.*

<b>CLIENT (IF DIFFERENT FROM ABOVE)</b>			
Name	<input type="text"/> <small>GIVEN NAME(S), INITIAL(S)</small>	<input type="text"/> <small>LAST NAME</small>	
Date of Birth	<input type="text"/> <small>D, D, M, M, Y, Y, Y, Y</small>		
Phone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/> <small>STREET NUMBER - STREET NAME - APT. /UNIT NUMBER</small>	<input type="text"/> <small>CITY / COMMUNITY</small>	<input type="text"/> <small>PROVINCE</small> <input type="text"/> <small>POSTAL CODE</small>

### Dental Hygienist's Information

Dental Hygienist's Name    
GIVEN NAME(S), INITIAL(S) LAST NAME

Place of Work

### Complaint Details

**NATURE OF THE COMPLAINT**

Communication issues       Unprofessional behaviour       Privacy/confidentiality

Other

**OTHER COMPLAINT DETAILS**

When did the incident occur?

If applicable, have you tried to discuss this complaint with the Dental Hygienist?       Yes     No

What do you hope to accomplish by submitting this complaint? (e.g., apology from the Dental Hygienist, assistance with resolution, etc.)

### Complaint Narrative PLEASE USE YOUR OWN WORDS TO DESCRIBE THE COMPLAINT

Signature of Complainant:       Date: