

Physiotherapist(s) name:

Name of the Facility or Physiotherapist's work location:

Address:

Street

City

Province

Postal Code

Names of other people who may have information regarding the complaint or witnesses (if applicable):

Not applicable

Full name:

First and last name

Address:

City

Province

Postal Code

Phone number:

Mobile Phone

Home Phone

Email address:

Relationship to patient:

My complaint

Please provide a description of your concerns about the physiotherapist. Please include dates or time periods, what the physiotherapist did or did not do, where the incident occurred and who was involved:

Please check box if you are providing additional documents:

SIGNATURES *required

Patient signature

Date

Representative signature

Date

*If someone completed this form on the patient's behalf

Submit your Complaints Reporting Form by mail, email or fax:

Email: registrar.cpm@manitobaphysio.com

Fax: (204) 474-2506

Mail: College of Physiotherapists of Manitoba

1465A Pembina Hwy

Winnipeg, Manitoba R3T 2C5

FOR OFFICE USE ONLY

Date complaint was received:

Name of the physiotherapist:

Name of the clinic:

Complaint #: