

Ontario Assoication of Osteopathic Practitioners

668 Silver Star Blvd. Unit 212, Tel: (416) 273-4751, Fax: (416) 551-5426 e-Mail: office@osteopathicboard.org

Complaint Form

Your Information

First Name:	Last	Name:		
Address				
City:	Province:	Postal Code:		
Home Phone Number:	Work	Phone Number:		
Cell phone number: Fax Number		umber:		
e-mail address				
Can we share your contact details with the osteopath ?		Yes	No	
Are you complaining for yourself?		Yes	No	
if yes,are you still seeing the osteopath?		Yes	No	
Are you complaining for a patient?		Yes	No	
If yes, what is your relation	ship to the patient?			
Does the patient know you are making this complaint for them		them? Yes	No	

The Manual Osteopathic Therapist's Information

First Name:	Last Name:
The address of the pract	ce
Phone Number:	Fax Number:
e-Mail Address:	
Were you refered to the th	rapist by other health care practitioner?
If yes, please give their	name and address
For how long had you (or the patient) rece	the patient) been going to the osteopath and how many treatments had ved?

Detailed Complaint:

Please describe the co	mplaint below,describing w	hat happened,	,where and when.F	Please also say if
there were any witnes	ses to the incidents. If you h	have any paper	rs or documents to	support your
complaint, please incl	ude copies of them with this	s formP.lease co	ntinue on an extra	sheet if you need to.
Please say how you (o	r the patient) paid for the os	steopathic treat	tment.	
Your own money	Health insuranc	Other		
Have you raised this s	amplaint directly with the a	stoopath?	Vos	No
nave you raised this co	omplaint directly with the o	steopatn	Yes	No
	what happened when you r	aised it with th	e osteopath.	
If no, please explain w	hy you decided not to.			
If you have raised this	complaint with anyone else	e, please say wl	ho it was and waht	t happened

Declaration:

I do not object to the osteopath seeing my complaint and I give my permission for any of my medical records and reports to be passed on to the Ontario Association of Osteopathic Practitionmers to help to investigate the claims I have made. I would be willing to appear as a witness at any heari that might take place.

I declare that the information I have given is true and accurate.

Signed:	Date:
,	nother person, please ask them to sign this form to show g made for them, they know about the procedures that will ermission to this.
Signed:	Date:

Check List:

Thank you for filling in this form. Please make sure you have:

given full details of the osteopath involved;

given as much information as you can about your complaint along with any supporting

filled in all sections of this form;

kept a copy of this filled-in form for your records;and

carefully read and signed the declaration.

Please send or fax the form to:

Fax Number: (416) 551-5425