PEIDC Prince Edward Island Dental College

COMPLAINT FORM

The Prince Edward Island Dental College (PEIDC) requests the completion of this form when filing a complaint against a dentist or a dental assistant registered with the College.

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 us through our website (peidc.ca/contact-us), or call 902-628-8156.

Complainant Information

PERSON FILING COMPLAINT

Name _____ _____
GIVEN NAME(S), INITIAL(S) LAST NAME

Address _____ _____ _____ _____
STREET NUMBER - STREET NAME - APT. /UNIT NUMBER CITY / COMMUNITY PROVINCE POSTAL CODE

Phone _____ Email _____

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.

CLIENT (IF DIFFERENT FROM ABOVE)

Name _____ _____
GIVEN NAME(S), INITIAL(S) LAST NAME

Date of Birth D D M M Y Y Y Y

Phone _____ Email _____

Address _____ _____ _____ _____
STREET NUMBER - STREET NAME - APT. /UNIT NUMBER CITY / COMMUNITY PROVINCE POSTAL CODE

Dental Professional's Information

Dental Professional's Name _____ _____
GIVEN NAME(S), INITIAL(S) SURNAME

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 involved health professional? ☐ Yes ☐ No

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

Complaint Narrative

PLEASE USE YOUR OWN WORDS TO DESCRIBE THE COMPLAINT

Signature of Complainant: _____ Date: D D M M Y Y Y Y