



## COMPLAINT FORM

*This report contains privileged information collected for review by the Quality of Care Committee.*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

What is the complaint? \_\_\_\_\_

\_\_\_\_\_

Who else is involved in the complaint? \_\_\_\_\_

\_\_\_\_\_

Have you brought the complaint to the attention of those directly involved?

Yes  No

What would you like to see happen to resolve this? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How can you be contacted to discuss the complaint?

Telephone #: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Cell #: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

**Bring or mail this form in an envelope marked:**

**Attention: Complaints**  
Admin. Assistant to D.o.O.  
Canadian Mental Health Association  
Windsor-Essex County Branch  
1400 Windsor Ave.  
Windsor, ON N8X 3L9