

Complaint Form

If you would like to talk to someone about the care you received from an optometrist, the optometrist's conduct, or the College's complaint process, please contact the College at:

Tel: 416-962-4071 or 1-888-825-2554

Fax: 416-962-4073

complaints@collegeoptom.on.ca

The College has no authority to deal with monetary issues, direct the optometrist to provide any kind of monetary compensation, or make a refund. The College's complaint process deals with professional conduct, competency or capacity of registered optometrists in Ontario.

To initiate a formal complaint about an optometrist, please complete this form and mail, e-mail or fax it to the College with a brief outline of your concerns on a separate sheet.

1. Person Filing Complaint			
Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>	Miss <input type="checkbox"/>	
Mr. <input type="checkbox"/>			
Dr. <input type="checkbox"/>			
	First Name	Middle Name	Last Name
Address:			
City:			
Province:			
Postal Code:			
Phone:		Home:	Work/Cell:
E-mail:			
Please Note: If an email address is provided, we will use email to communicate with you regarding your complaint. Alternatively, please check here to receive our letters by mail: <input type="checkbox"/>			
<i>If you are not the patient, please describe the relationship to the patient (parent, spouse, child, relative, health care professional, lawyer, friend, etc):</i>			

2. Patient Information (if different from above)			
Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>	Miss <input type="checkbox"/>	
Mr. <input type="checkbox"/>			
Dr. <input type="checkbox"/>			
	Patient's First Name	Middle Name	Patient's Last Name
Address:			
City:			
Province:			
Postal Code:			
Phone:		Home:	Work/Cell:
E-mail:			

Complaint Form

The optometrist you are complaining about will be notified of your complaint within 14 days. A copy of your complaint will be provided to the optometrist and (s)he will be asked to respond to it.

3. Optometrist(s) you are complaining about	
Optometrist's Name:	
Practice Address:	
City:	
Province:	
Postal Code:	
Phone:	

4. Details of Complaint
<p>On a separate sheet, please provide a brief outline of your concerns, including the following:</p> <ul style="list-style-type: none"> • Date(s) of service • Reason(s) you are concerned about the care you received, the optometrist's behavior, etc. • Detail any efforts you have made to resolve the matter • Any supporting document(s) with an explanation of how each relate to your concern(s) <p>Please note: <i>If you are submitting a complaint about the care you received or if the patient is a minor child and you are the parent / guardian, please complete and sign the consent form on the next page and attach it to your complaint form. If you are submitting a complaint on behalf of another patient, please make sure the patient has completed and signed the form on the next page after carefully reviewing it.</i></p>

Please e-mail, fax or mail your complaint to:

E-mail: complaints@collegeoptom.on.ca

Fax: 416-962-4073

Mail: Coordinator, Investigations and Resolutions

College of Optometrists of Ontario

65 St Clair Ave E, Suite 900

Toronto ON M4T 2Y3

Pour obtenir une version française de ce formulaire, veuillez envoyer un courriel à:

complaints@collegeoptom.on.ca

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5. Consent for Release of Personal Health Information

As part of our investigation we may need to obtain your relevant personal health information including your patient record from the optometrist(s) you complained about, from health care practitioners who treated you and/or from facilities at which you were treated related to the optometric care you received. For this purpose, we ask that you complete the following form:

I, _____, Date of Birth _____

Consent to the release of my personal health information to the College of Optometrists of Ontario by the following:

A. The Optometrist(s) you are complaining about:

Optometrist's Name:	
Address:	

If you wish to complain about additional optometrist(s), please attach additional consent pages as needed and sign each page.

B. Other optometrist(s) (who are not the subject of my complaint) / ophthalmologist(s) / health care practitioners / facilities who treated me related to the optometric care I received:

1. Name:	
Address:	
2. Name:	
Address:	

If additional optometrist(s), health care practitioner(s) or facilities were involved, please attach additional consent pages as needed and sign each page.

The College has a duty of confidentiality with respect to all information obtained in the course of its investigation. However, the College may share some or all of your personal health information with the optometrist(s) who are the subject(s) of the complaint.

If either you or the optometrist(s) appeal the College's decision, medical information and other information collected during the investigation must be disclosed to the Health Professionals Review and Appeal Board, which is a public forum.

I understand the purpose for which this consent is given. I understand that I can withdraw or limit my consent at any time by providing written notice to the College. I understand that I can refuse to sign this consent form. However, I understand that the College may proceed in the absence of patient consent and reach a decision without having the benefit of this information.

Date

Patient's Name

Signature of Patient