**Complaint Form Authorization for Consent and Release of Information**

Please fill in the Complaints form below. To learn about the full complaints process, please review the Complaints Process on the CMRIPS website www.cmrips.org.

If you have questions, please contact the Executive Director/Registrar by phone: (306) 525-1434 or email: debbieschatz@cmrips.org.

Submit via email to debbieschatz@cmrips.org.

**YOUR INFORMATION**

First Name\* Click or tap here to enter text.

Last Name\* Click or tap here to enter text.

Address Line 1\* Click or tap here to enter text.

Address Line 2 Click or tap here to enter text.

City\*Click or tap here to enter text.

Country Click or tap here to enter text.

Province Click or tap here to enter text.

Postal Code/Zip Code\* Click or tap here to enter text.

Primary Phone\* Click or tap here to enter text.

**THE MEMBER YOU ARE COMPLAINING ABOUT (RESPONDENT)**

Medical Radiation & Imaging Professional Click or tap here to enter text.

Place of Work Click or tap here to enter text.

Street Address 1 Click or tap here to enter text.

Street Address 2 Click or tap here to enter text.

City Click or tap here to enter text.

Country Click or tap here to enter text.

Province/State Click or tap here to enter text.

Postal Code/Zip Click or tap here to enter text.

**COMPLAINT**

Describe the incident(s) that took place in as much detail as you can provide, including when and where the incident(s) occurred. If you require assistance identifying individual, please contact us directly at info@CMRIPS.org.

Click or tap here to enter text.

**PATIENT INFORMATION**

Provide the names and the relationship between the complainant and the patients or any additional patients who are involved in the complaints.

Click or tap here to enter text.

**WITNESS INFORMATION**

Provide the names, addresses, phone numbers and details of any other individual(s) and the details of the information they may have pertaining to the complaint (i.e. other health professionals).

Click or tap here to enter text.

**SUPPORTING DOCUMENTATION** (Optional)

Other supporting documents can be attached with this form and submitted via email.

**ACKNOWLEDGEMENT** [ ]  ,

I as the complainant, agree to the following terms in submitting my complaint: \*

1. The CMRIPS member in question will be provided an opportunity to respond to the concerns outlined in the complaint.
2. CMRIPS will provide the member with a copy of the complaint and may share some or all the information and documentation collected during the investigative process.
3. CMRIPS may communicate with any person or persons who may be able to assist with the investigation of this complaint.
4. My name will be released to the CMRIPS member in question and the CMRIPS Discipline Committee for the purpose of conducting a thorough investigation.
5. I will allow for a recorded interview (audio and/or video) with a CMRIPS-appointed investigator.
6. I understand the constraints and obligations of the investigative process as described on the CMRIPS website.
7. If the patient is deceased, privacy rights for deceased patients continue after death unless one of the exceptions stated in Section 27(4)(e) of The Health Information Protection Act (HIPA) applies:
8. where the disclosure is being made to the personal representative of the subject individual for a purpose related to the administration of the subject individual’s estate; or
9. where the information related to circumstances surrounding the death of the subject individual or services recently received by the subject individual, and the disclosure:
10. is made to a member of the subject individual’s immediate family or to anyone else with whom the subject individual had a closer personal relationship; and
11. is made in accordance with established policies and procedures of the trustee, or where the trustee is a health professional, made in accordance with the ethical practices of that profession.