COLLEGE of OCCUPATIONAL THERAPISTS of NOVA SCOTIA

COMPLAINT FORM

Instructions

Please complete the below information to submit a complaint to the College. You must provide the name of the Occupational Therapist you are concerned about, as much detail as possible about the nature of your concerns, as well as your full contact information. All required item are marked with an asterisk (*). Additional information or supporting documents that you wish the College to consider may be attached to this complaint form. You should be aware that a copy of the complaint and any supporting documentation may be shared with the Occupational Therapist during the course of the investigation.

In order for an investigation to be initiated, you must sign this complaint form. Anyone may file a complaint with the College. If you have any questions or concerns, contact the College at 902-455-0556 or 1-877-455-0556.

Send the completed form to:

Registrar
College of Occupational Therapists of Nova
Scotia 380 Bedford Hwy, Suite 302
Halifax, NS B3M 2L4

1. Person Registering Complaint

First Name*:_____ Last Name*:_____

Primary telephone:_____ Secondary telephone:_____

E-mail:_____

Address*: _____

City*:_____ Province*:_____ Postal Code*:_____

What do you hope to accomplish by submitting this complaint?

2. Occupational Therapist Information

First Name*:_____ Last Name*:_____

Employer Name:_____

3. Incident Information

Date(s) for specific incident(s), if applicable:_____

Please describe your specific concern(s) about the occupational therapist's conduct and provide sufficient information to fully explain the nature of your concerns(additional pages may be attached)*:

Signature:_____ Date:_____

4. Health Information

Are there other any other health care provider(s) (i.e. medical doctors, physiotherapists, hospitals) who have information relevant to your concerns? ☐ Yes ☐ No

Name	Employer	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supporting information or documents:

_____

_____

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Consent and Authorization to Release Information

I consent and authorize the College of Occupational Therapists of Nova Scotia to collect, use, and disclose any health records for the purposes of investigating the attached complaint in accordance with the *Occupational Therapists Act*.

Client Full Name:_____

Date of Birth:_____ Health Card #:_____

Signature:_____ Witness:_____

Name:_____

Address:_____

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