Canadian Mental Health Association
North Bay and District

Association canadienne pour la santé mentale
North Bay et District

EXTERNAL COMPLAINT FORM

If you were not satisfied with the care or healthcare experience provided by CMHA North Bay and District, you can file an external complaint after you have attempted to resolve your complaint directly with your caregiver or the Organization.

To make a complaint, please complete all sections of this form and send it to us by regular mail, courier or e-mail. See **Page 4** for details.

1. Contact Information

First Name	Last Name	Preferred Name (Optional)	
Street Number	Street Name	Apt. or Suite #	
City		Province	Postal Code
Telephone		Email (Optional)	

Are you making this complaint on behalf of someone else? ☐ **YES** ☐ **NO**

If YES, please provide the following information about the (former or current) client. **If NO skip to Section 2: Contact Preferences**

First Name	Last Name	Preferred Name (Optional)	
Street Number	Street Name	Apt. or Suite # (Optional)	
City		Province	Postal Code

Did the (former or current) client ask you to make this complaint?

YES **NO**

Is that person deceased? ☐ **YES** ☐ **NO**

2. Contact Preferences

Preferred contact method:

Telephone   Regular Mail   Email *

* Note: CMHA North Bay and District cannot guarantee the privacy or security of information shared using email. By selecting this option, you confirm that you understand and accept the risks.

Please check preferred language:

English   French   Other ____________________________

Please identify any required accommodations:

TTY device   Interpreter   Other____________________________

3. Health Organization Information

Organization Name:			
Street Number	Street Name	Site (Optional)	
City		Province	Postal Code
Telephone		Email (Optional)	

Please list the service you received in relation to your unresolved complaint:

____

Please provide the contact information for the person at the Organization that dealt with your complaint:

First Name	Last Name	Position or Title and Department (Optional)
Telephone		Email (Optional)

Is there another health organization involved that you are also concerned about?

☐ **YES**   ☐ **NO**   If yes, please provide the name. ____________________________________

176 Main St. West, North Bay ON P1B 2T5 Tel: 705-476-4088 www.nbd.cmha.ca

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4. Complaint Details

Please describe your complaint. Tell us what happened; who was involved; when and where it happened; when you became aware of the problem; the main issues with which you are concerned. Feel free to continue using additional pages.
What would you like to happen to resolve your complaint? For example, an apology, additional information, change to a policy, etc.
Did you attempt to resolve your complaint directly with the Organization? ☐ **YES** ☐ **NO**
If yes, please describe what resolution(s) the Organization suggested.
Suggested Resolutions:
Did you complain to another organization or person? ☐ **YES** ☐ **NO** ***If yes, please provide the name.*** ____________________

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5. Notice of Collection

If you are a caregiver or another person making a complaint on behalf of a former or current client, we need the consent of the client or their substitute decision-maker in order to obtain / disclose information about the individual. No information can be disclosed without the consent of the client of substitute decision-maker.	
Signature of Client or SDM	**Date Signed (dd/mm/yyyy)**

Once you have completed and signed this complaint form, please send it to our office using one of the methods below.

(a) Mail or courier to:

CMHA North Bay and District
176 Main St. West
North Bay, ON P1B 2T5

(b) E-mail to:

Jodi Steeves
Director of Human Resources
jsteeves@nbd.cmha.ca

If you are having difficulties completing the form or have questions, you can contact us Monday to Friday between the hours of 9 a.m. to 3 p.m. by phone at 705-476-4088 or toll-free at 1-844-476-4088. We are here to help.