COMPLAINT FORM

Your Contact Information

Name: ____
Last First

Address: ____
Street Address Apt #

____
City Province Postal Code

Contact Number: (______) ____

Regulated Member whom you are submitting a complaint against

Name: ____
Last First

Address: ____
Street Address

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City Province Postal Code

Phone: (______) ____

Details of your complaint (attach additional sheets(s) if necessary)

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Please describe the attempt(s) that you have made to resolve your complaint with the Regulated Member

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Knowing that the College cannot direct the reimbursement of any monies you have paid to the Regulated Member, what outcome do you want as a result of this complaint process?

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Authorization for collection, use, release and disclosure of information I understand my signature on this complaint reporting form will allow the College of Hearing Aid Practitioners of Alberta:

a) To collect records or other information relevant to my complaint
b) To release and disclose a copy of my complaint to the Regulated member being complained about (complainant), and any investigator(s) assigned, any expert(s) requested to review the matter on behalf of CHAPA, and any other process as described under part 4 of the HPA
c) To use, release and disclose, where applicable, and in accordance with the HPA, information concerning my complaint including personal identifiable information in order to investigate certain matters. By submitting this authorization form, I hereby consent to the College of Hearing Aid Practitioners of Alberta to collect, use, release and disclose of any and all information that may be related to my complaint including personal/confidential information for professional conduct and other regulatory purposes, in accordance with the Health Professions Act and Personal Information Privacy Act.

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Signature of Person making complaint   Date

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Witness (Please sign and print name)   Date