Health Care Facility Complaint Form

This information MUST be completed to investigate your complaint.
Incomplete forms CANNOT be processed.

Health Care Facility Information:

Name of Facility: _____
Facility Type License Number

Address: _____

Phone number(s):_____ Email: _____

Health Care Provider Information:

Name of Employee: _____
Profession License Number

Address: _____

Phone number(s):_____ Email: _____

Complainant Information:

Agency/Company Name (If applicable): _____

Your Name: _____
Last First M.I.

Address: _____

Phone Number: _____Email: _____

Patient Information:

Please complete this section if you are not the patient.

Name: _____

Last First M.I.

Address: _____

Phone Number: _____ Date of Birth: _____

Your relationship to the patient:

☐Parent ☐Son/Daughter ☐Spouse ☐Brother/Sister ☐Friend ☐Legal Guardian ☐Other

Please provide documentation indicating your appointment as the legal authority/guardianship or personal representative.

The Department does not investigate complaints regarding the amount charged for a procedure, broken or missed appointments, customer service, bedside manner, rudeness, professionalism, personality conflicts or events which happen more the six (6) months prior.

Provide a complete description of the complaint/report.
Include facts, details, dates, locations, etc. (who, what, when and where)
Attach additional sheets if necessary.

Please make and attach copies of medical records, correspondence, contracts and any other documents that will help support your complaint. Failure to attach records will delay the investigation.

Date of Incident: _____

The complaint form must be signed and returned to the Department.

Signature:_____Date: _____

(Required to file complaint)

You may scan and return the form via email to:

complaints@hra.gov.tc

You may mail the form to:

Health Regulation Authority
Town Center Mall, Downtown
Providenciales, TCI

You may call for assistance:

649-338-4924

Unlicensed Activity

Only complete this page if your complaint is for unlicensed activity.

What is your relationship to the subject? _____

How did you become aware of the alleged unlicensed practice? _____

When did you become aware of the alleged unlicensed practice? _____

Location of alleged unlicensed practice: _____

Time and date of treatment or incident: _____

If payment was made, how was subject paid? _____

Does the subject or subject's business accept insurance? _____

Names and addresses of patients/victims/witnesses aware of your complaint:

Name: _____

Address: _____ Phone: _____

Name: _____

Address: _____ Phone: _____

Name: _____

Address: _____ Phone: _____

Names of other employees/licensees at the same location or business:

_____

_____