Health Professionals Council (Seychelles)

TITLE: Complaint Form		
Form Number: HPC-F017-SOP-008	**Revision Number**: 0	Page **1** of **2**
Effective Date: Aug 2019	**Review Date**: Aug 2020	**Document Level**: 4

Please use **BLOCK LETTERS** to complete ALL sections of this form.

SECTION A – Personal details of Complainant

Full name ……

Residential Address …… …… ……

Mailing Address …….. …….. ……..

Tel. Number Home: …… Work: …… Cell: ……

Email Address: ……

SECTION B – Particulars of Complaint

☐ 1. Against an AHP ☐ 2. Against an allied health service ☐ Other (*Please specify*):

……..

Name of registered health professional: ……

Registered profession: ……..

Physical work address: …….

Registration number (*if known*): ……..

Field of allied health service (as applicable): ……..

Business name (as applicable): ……

Business address: ……..

State the complaint:

……....
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Attach any relevant documents pertaining to the complaint (*e.g. adverts, appointment cards, photos, etc*….)

Do you have any suggestions in regards to the complaint?

Date of occurrence:	……..
Place of occurrence:	……

Disclosure:

I hereby declare that all information provided on this form is true and correct to the best of my knowledge. I understand that providing misleading information may result in no action being taken against the accused. The Council may hold my personal information which shall be disclosed to other parties only through my expressed consent.

Signature of complainant: ……..

Signed at: ……

Dated this: ……

OFFICE USE ONLY		
Complaint Number	HPC/CM/…….	
Complaint received by:	…… (Name)	…….. (Sign)
Complaint recorded by:	…… (Name)	…….. (Sign)
Date of receipt:		
Date of record:		
Date of acknowledgement of receipt of complaint:		

Signature of Registrar: …… Date seen: …….

Signature of Chairperson: …….. Date seen: …….