COLLÈGE DES MÉDECINS
DU QUÉBEC

Inquiries Division
Office 3500
1250, René-Lévesque Boulevard West
Montreal QC H3B 0G2
Tel.: (514) 933-4787 or 1 888 633-3246, ext. 4787
Fax: (514) 933-2291
Email: info@cmq.org

Investigation Request Form

You may complete this form to submit an investigation request. Please be sure to include a brief summary of your concerns on the last page (see Section D).

The form can be completed on screen and then printed out, or you can print it out first and fill it in by hand. Duly completed and **signed** investigation requests can be forwarded at the Inquiries Division, at the above mentioned coordinates.

If you have any questions about the investigation process or the professional conduct of a physician, you can contact the Inquiries Division at the Collège des médecins du Québec or consult our website at www.cmq.org.

A) Applicant's Coordinates

Please note that the coordinates you provide are the ones that the Collège des médecins du Québec will use to contact you.

Mr. ☐ Mrs. ☐ Family Name _____ First Name _____

Address (No.) _____ Street _____ Apt. _____

City _____ Postal Code _____

Province _____ E-Mail Address _____

Telephone (residence) _____ Telephone (work) _____

Telephone (cell.) _____

If you are the patient, please indicate your:

Date of Birth _____ Health Insurance Number _____

If you are not the patient, please indicate your relationship to the patient and provide his/her coordinates in section B.

_____

Furthermore, **if you are making your request for an organization or a company**, please fill out the following additional fields.

Organization or Company _____

Title or position _____

B) Patient's Coordinates (do not complete if the same as in section A)

Mr. ☐ Mrs. ☐ Family Name _____ First Name _____

Address (No.) _____ Street _____ Apt. _____

City _____ Postal Code _____

Province _____ E-Mail Address _____

Telephone (residence) _____ Telephone (work) _____

Telephone (cell.) _____

Date of Birth _____ Health Insurance Number _____

C) Coordinates of the Physician Concerned

Please provide as much information as possible to help us identify the physician.

Family Name _____ First Name _____

Specialty _____

Where did the consultation with this physician take place?

Hospital ☐ Office (clinic) ☐ Walk-in clinic ☐ Other (specify) _____

Name of the clinic or healthcare establishment _____

Address (No.) _____ Street _____ Office _____

City _____ Postal Code _____

Province _____ Telephone _____

If your request involves other physicians, please provide details on a separate page.

D) Brief Summary of your Concerns

On the following page, provide a description of the situation, including:

- the nature of your complaint or source of dissatisfaction;
- your reason(s) for consulting this physician;
- the place where the consultation(s) or event(s) occurred;
- the date(s) on which the medical consultation(s) or treatment(s) took place;
- details of actions taken to attempt to resolve the problem with the doctor or hospital, if applicable;
- your expectations regarding this investigation request.

If necessary, you may add one or more sheets.

Please attach a copy of any documents that could be pertinent to the review of your request.

Signature (required) Date

D) Brief Summary of your Concerns